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AN EVALUATION OF THE 1989 RESTRUCTURING
OF THE NAVY MEDICAL DEPARTMENT
FROM THE PERSPECTIVE OF FINANCIAL MANAGERS

by

John C. Espie IV

December, 1991

Thesis Advisor: Susan Page Hocevar

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FROM THE PERSPECTIVE OF FINANCIAL MANAGERS

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ABSTRACT

This thesis examines the perceptions of personnel of the Navy Medical Department regarding the organizational restructuring which took place in 1989. Included in the thesis is a background discussion of the change effort including underlying causes, the nature of the restructuring, and implementation methods. Data for the thesis came from reference reviews, personal interviews with key players, and a survey questionnaire. The target population for the survey questionnaire was the financial management professionals within the Medical Department. The change effort is evaluated utilizing models drawn from change literature and focuses on comparing planned versus perceived actual outcomes, the perceptions of effectiveness of change leadership, and the perceived current status of management indicators.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF TABLES IN APPENDICES

I. INTRODUCTION

A. Area of Study

This thesis is about change. It is about the way change is conceived and implemented in a large organization, and how specific members of that organization perceive the change process and the results of the change. It is about measuring the success of a change effort.

In this thesis, the change effort that is studied is the 1989 restructuring of the United States Navy Medical Department. It is studied from the viewpoint of the members of the Medical Department defined as Financial Management Professionals. The purpose of the study is to evaluate the perceived success of the change effort.

B. Scope of the Thesis

In their book "Changing Ways", Murray M. Dalziel and Stephen C. Schoonover, describe successful change as one in which "...change leaders share information with those most affected by change to instill consistent expectations about the change and its ramifications throughout the organization" [Ref. 1:p. 16]. One focus of the thesis, therefore, is to compare the objectives of the change effort undertaken in the 1989 restructuring, as stated or defined by the change leaders, with the objectives perceived by the Financial

Professionals in the Medical Department. The study is limited to objectives dealing specifically with the financial management of the Medical Department, but also examines some of the broader objectives of the Medical Department as a whole.

Also included in the scope of the thesis is an evaluation of the change effort based upon the perceived effectiveness of the change leadership and on perceived outcomes. The evaluation of leadership is based upon the effectiveness of the change leadership at determining, communicating and implementing the objectives of the change at both Headquarters and lower echelons. Outcomes are evaluated based on a comparison of the study respondents' perceptions of the status of specific criteria relating to the Medical Department's structure, mission, and environment, both before and after the change effort.

C. Primary and Secondary Research Questions

The research questions explored in this thesis are listed below.

1. Primary Research Question:

The primary research question of this thesis, based upon the perceptions of the Financial Management Professionals, is: Was the change effort defined as the 1989 restructuring of the Department successful? This question has two major aspects. First, did the restructuring accomplish the overall and

financial management objectives envisioned by the change planners? Second, is the restructured Medical Department the remedy required to cure the long-standing problems facing Navy Medicine?

2. Secondary Research Questions:

1. What were the underlying causes of the change effort and who were the primary change agents?
2. What organizational and financial management objectives did the change leaders envision being achieved as a result of the restructuring?
3. How were these objectives communicated to the implementing activities?
4. How consistent were the implementers of the change at the Headquarters and Field Activities at interpreting the objectives of the restructuring?
5. How do personnel in different demographic groups (i.e.; Headquarters versus Field) view the change effort?
6. How do perceptions of the current overall and financial management operations compare with perceived effectiveness of operations before the restructuring?

D. Organization of the Thesis

The remainder of this thesis is divided into five chapters. The content of each chapter is described below.

- Chapter II Background: Description of the Navy Medical Department including: a history of the department; the mission, structure, and procedures of the Department of the Navy Medical Blue Ribbon Panel; the old and new organizational structures; and the implementation of the Blue Ribbon Panel recommendations.
- Chapter III Theoretical Framework: A description of organizational change processes as described in management literature utilizing models which focus on change

implementation, measurement of planned to actual outcomes, and classifying the success of change efforts.

- Chapter IV Methodology and Data: A description of the techniques used for data collection and analysis.

- Chapter V Results: A presentation and analysis of the data collected from interviews and surveys as they relate to the primary and secondary research questions.

- Chapter VI Conclusions and Summary: An evaluation of the success of the Navy Medical Department in implementing the change effort based upon the theoretical models described in Chapter III and the analysis of data in Chapter V as they relate to the primary and secondary research questions .

- Appendices A through C: These appendices include the Survey Questionnaire, data tables, and references.

E. Definitions and Acronyms

The following definitions and acronyms are used throughout this thesis.

1. Bureau of Medicine and Surgery (BUMED): Headquarters activity of the Navy Medical Department following the 1989 restructuring. Successor activity to the Navy Medical Command.

2. Dental Treatment Facility (DTF): Navy Dental Clinic.

3. Department of the Navy Medical Blue Ribbon Panel (BRP): Temporary panel chartered to study and recommend changes for improving mission performance of the Navy Medical Department.

4. Field Activities: All commands of the Navy Medical Department not defined as a Headquarters or Other Activity.

5. Geographical Command (GEOCOM): Echelon three command reporting to the Navy Medical Command responsible for specific operations of medical and Dental Treatment Facilities within a geographical region.

6. Headquarters Activities: Prior to the 1989 restructuring, these consisted of NAVMEDCOM and the GEOCOMs. After 1989 these consisted of BUMED and the HSOs.

7. Healthcare Support Office (HSO): Detachments of BUMED created as a result of the 1989 restructuring who perform regional coordination, consolidation, and support functions.

8. Medical Treatment Facility (MTF): Navy Hospitals and Clinics.

9. Navy Medical Command (NAVMEDCOM): Primary headquarters activity of the Navy Medical Department prior to the 1989 restructuring. Predecessor activity to the Bureau of Medicine and Surgery.

10. Navy Medical Department: All Headquarters, Field, and Other Activities who report directly or indirectly to the Surgeon General.

11. OP-093: The Office of the Director of Navy Medicine/Surgeon General under the Chief of Naval Operations.

12. Other Activities: Offices and Commands which are part of the Navy Medical Department but not defined as either a Headquarters or Field Activity. These include commands with research, education, and environmental health missions, as well as OP-093.

13. Regional Line Commander (RLC): After the 1989 restructuring, the line officer in a specific region responsible for the provision of medical care to beneficiaries within the region.

14. Surgeon General (SG): A Medical Corps Vice Admiral who serves as the Director of Navy Medicine (OP-093), and as the Commander of the Bureau of Medicine and Surgery. The senior officer of the Navy Medical Department.

II. BACKGROUND OF THE CHANGE EFFORT

A. HISTORY OF THE NAVY MEDICAL DEPARTMENT[1]

The Navy Medical Department has existed as an entity almost from the creation of the Navy itself. For most of its life it was known as the Bureau of Medicine and Surgery (BUMED), and, consisted of a headquarters activity which coordinated the recruitment, assignment, and training of medical personnel, along with the various branch hospitals around the world. The reporting chain for hospital commanders varied according to the size and location of the facility. The hospital commanders reported to either the local base commanders, the commandant of the naval district, or BUMED.

In 1974 the responsibilities of BUMED greatly expanded, and the chain of command was redirected. Hospital Commanders no longer reported to base commanders. Instead, they reported to the commanders of the nearest major medical treatment facility. These facilities were renamed Naval Regional Medical Centers (NRMC) and typically had from two to five subordinate commands. The NRMC Commanders, in turn, reported directly to the Chief of BUMED, who was also the Surgeon

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[1] Much of the material appearing in this section was previously published in the article *"Managing Organizational Change within the Navy Medical Department"* by Lt John C. Espie, Navy Comptroller, Vol. 1, No. 1, September 1990.

General and the Medical Resource Sponsor in the office of the Chief of Naval Operations (CNO), Code OP-093.

In 1982, the Inspector General of the Navy determined that the Surgeon General's span of control had become too broad to effectively manage the Medical Department. The NRMCs were dissolved and a new echelon of command was established. Eight regional commands, known as Geographical Commands (GEOCOMs), were created. All fixed medical treatment facilities within the region reported to the GEOCOM Commander. BUMED was renamed The Navy Medical Command (NAVMEDCOM), and placed under the command of a Rear Admiral. The Surgeon General was limited to the performance of his OP-093 duties.

These rapid changes in organization were primarily driven by external forces. The rising cost of medical care, increasing Civilian Health and Medical Program of the Uniform Services (CHAMPUS) payments, the shortage of medical care providers, and the increasing focus on quality assurance, all stimulated reevaluation of the organizational structure and a continuing search for methods to improve economy and efficiency.

During this period the provision of medical care was viewed as strictly the concern of the Medical Department. However, in spite of their rank and role as a resource sponsor, the Surgeons General discovered they had a difficult time competing for resources with line requirements. As a result, subsequent funding and personnel constraints resulted

in a drain of resources from the treatment facilities in order to establish and operate the GEOCOMs. As the GEOCOMs grew through the accrual or assignment of additional mission functions, the drain on the medical resources of the treatment facilities was aggravated. This led to increased provider shortages and a further reliance on CHAMPUS. Thus the reorganized Medical Department was unable to correct the problems it was designed to combat.

B. THE DEPARTMENT OF THE NAVY MEDICAL BLUE RIBBON PANEL[2]

1. Establishment and Mission

In April of 1988, the Navy Inspector General reported to the CNO that the 1982 reorganization had failed to achieve its objectives. The Inspector General wrote:

> Despite the extensive reorganization initiated from recommendations of the Naval Inspector General's inspection of BUMED in 1982, the leadership of navy medicine has been unable to sustain the needed quantity of medical care or readiness when faced with scarce fiscal and personnel resources. Morale of medical personnel continues to fall and beneficiary frustration with perceived loss of health care benefits and difficulty with access is growing....It is imperative that a clearly defined organization which will provide strong leadership, management expertise, cohesiveness and purpose be implemented, nurtured and held accountable if a viable Navy health care delivery system is to be resurrected. [Ref. 2:p. 2]

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[2]. Except where cited by direct reference, material presented in the remainder of this chapter was compiled from a review of the documents listed in Appendix C, and from personal interviews with members of the BRP task forces, MED-01, and OPNAV.

The Inspector General went on to list numerous recommendations for improving the operations of Navy medicine.

On 24 May, 1988, the CNO issued a memorandum which established the Department of the Navy Medical Blue Ribbon Panel (BRP). The mission of the BRP was to investigate and develop short and long term solutions for the problems of the Navy's health care delivery system. [Ref. 3:p. A-1]

2. Organizational Structure of the Blue Ribbon Panel

The BRP was composed of eight members and was chaired by the Vice Chief of Naval Operations (VCNO). The other members of the panel were:

- Director of Navy Medicine (OP-093)
- Deputy CNO (Navy Program Planning) (OP-08)
- Deputy CNO (Logistics) (OP-04)
- Deputy CNO (Manpower, Personnel and Training) (OP-01)
- Director of Marine Corps Logistics Plan, Policies, and Strategic Mobility (CMC(LP))
- Assistant Secretary of the Navy (Manpower and Reserve Affairs) (ASN(M&RA))
- Past President, Maine Medical Center

The membership of the panel was designed to overcome traditional medical/line divisions of authority and give a broad spectrum of senior decision makers opportunities to address Navy medicine's problems. A distinguished physician from the civilian sector was included to provide private sector perspective and insight. [Ref. 3:p. 15]

Subordinate to the BRP was a Flag Officer Working Group (FOWG). This group consisted of 18 members who were recognized as subject matter experts with the requisite knowledge and experience to investigate specific problems found in the Medical Department. The FOWG was responsible for developing reports and recommendations for BRP consideration.

Task forces, chaired by members of the FOWG, studied the following functional areas:

- Organization and Management
- Clinical Operation and Medicine
- Manpower, Personnel and Training
- Contracting
- Budget execution
- Equipment Procurement and Maintenance

The mission of the task forces was to identify and examine problems within their area of expertise. For each identified problem, the task forces explored alternative solutions, proposed recommendations and implementation plans, prepared cost estimates, and reported progress to the FOWG. With some limitations, the task forces were given the authority to take appropriate action to resolve problems. When those problems were beyond that authority, their conclusions and recommendations were forwarded to the FOWG and BRP for action as appropriate.

The FOWG reviewed the progress of the task forces at twelve meetings over the period May 1988 through May 1989. The BRP itself met six times during the same period. Although the above meetings were still being conducted to monitor progress, the final report of the BRP, which contained a summary of all findings and recommended actions, was published on 21 November 1988.

C. ORGANIZATIONAL STRUCTURE OF THE NAVY MEDICAL DEPARTMENT

1. Navy Medicine

The organizational structure of Navy medicine as it existed from 1982 - 1989 is shown in Figure 1. The Organization and Management Task Force identified three problems resulting from this structure. These were:

1. Surgeon General (OP-093) lacks clear command/control authority.
2. GEOCOMs consume manpower and do not properly perform the intended functions.
3. Naval Medical Clinic Commands unnecessarily consume limited health care resources.

Specific structural changes to the Medical Department were recommended as solutions to the above problems. Reorganizing the Office of the Surgeon General and NAVMEDCOM back to the BUMED structure under command of the Surgeon General was recommended as the solution to problem 1. The solution to problem 2 was a recommendation to eliminate the

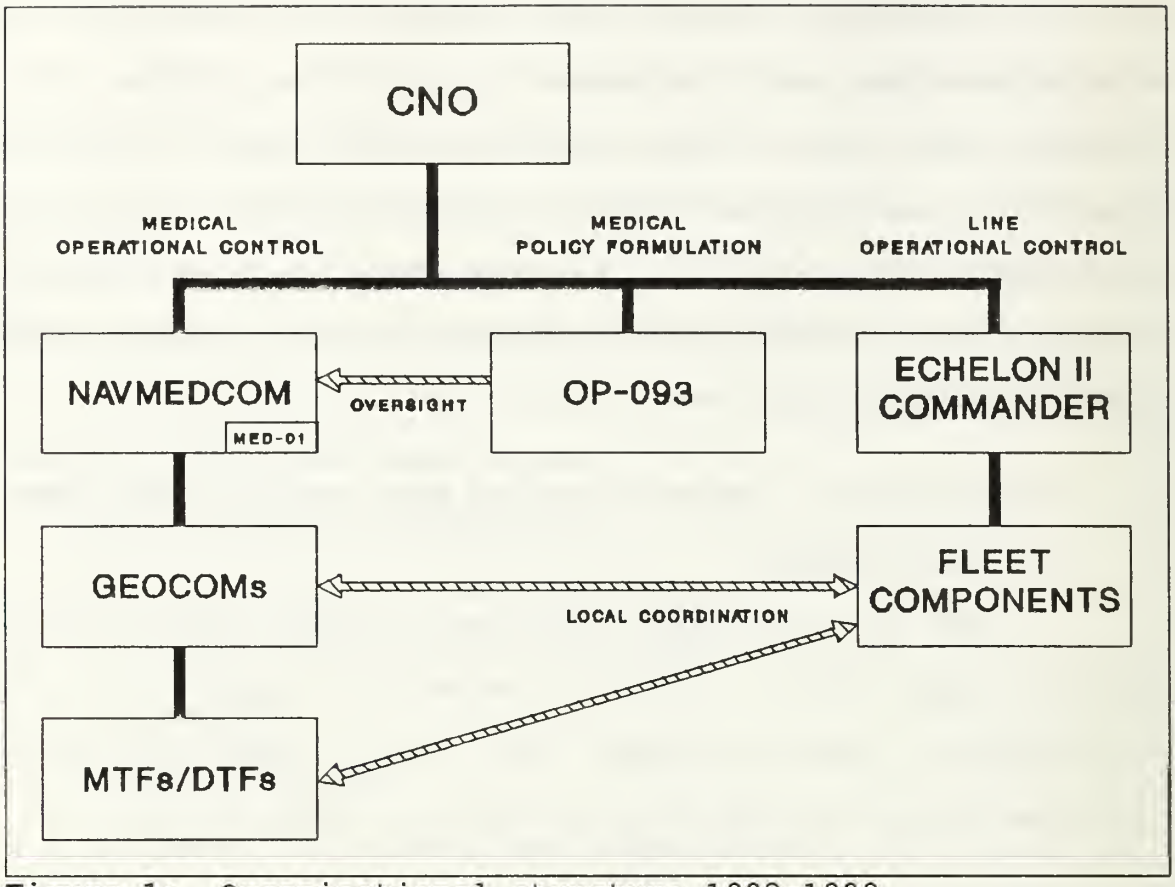

Figure 1: Organizational structure 1982-1989

echelon of command represented by the GEOCOMs and return both the personnel and funding to the MTFs/DTFs. In addition, it was recommended the command of the regional clinics be returned to the MTFs as the solution to problem 3.

The task force also recommended assigning responsibility for the provision of medical care to the line. Line responsibility was to be exercised by rerouting the chain-of-command for the field activities. The basis for this recommendation is contained in the Final Report of the BRP.

It reads:

> The Task Force also concluded...that the lack of line involvement/responsibility in resourcing the medical department was detrimental. Line commanders expressed concern over their inability to resolve problems concerning access to medical care. The Task Force considers Medical Type Commanders (MEDTYCOMs) subordinate to the Fleet Commanders in Chief (CINCs), as replacements for the GEOCOMs, would improve resource allocation and line involvement. The CINCs would be responsible and/or accountable for allocating resources to their medical priorities. [Ref. 3:p. 25]

As this recommendation represented a radical shift in the focus and operations of both the Fleet Commanders and the Medical Department, the BRP recommended that a 90 day study group be established to "identify the best plan and schedule for transitioning to a MEDTYCOM organization" [Ref. 3:p. 26]. This study was conducted under the auspices of the Center for Naval Analysis (CNA). It was headed by two retired line admirals, with the participation of personnel from NAVMEDCOM, OPNAV, and the Fleet.

The report of the CNA study was presented to the BRP in February 1989. The report concluded that the MEDTYCOM structure recommended by the BRP was unworkable. This was based primarily on two factors: the unwillingness of the Fleet Commanders to assume full control for medical operations; and the difficulties in allocating and distributing resources, particularly CHAMPUS dollars.

Instead of the MEDTYCOM, the study recommended the establishment of a dual chain-of-command for navy medicine as shown in Figure 2. Under this concept, Military Command of

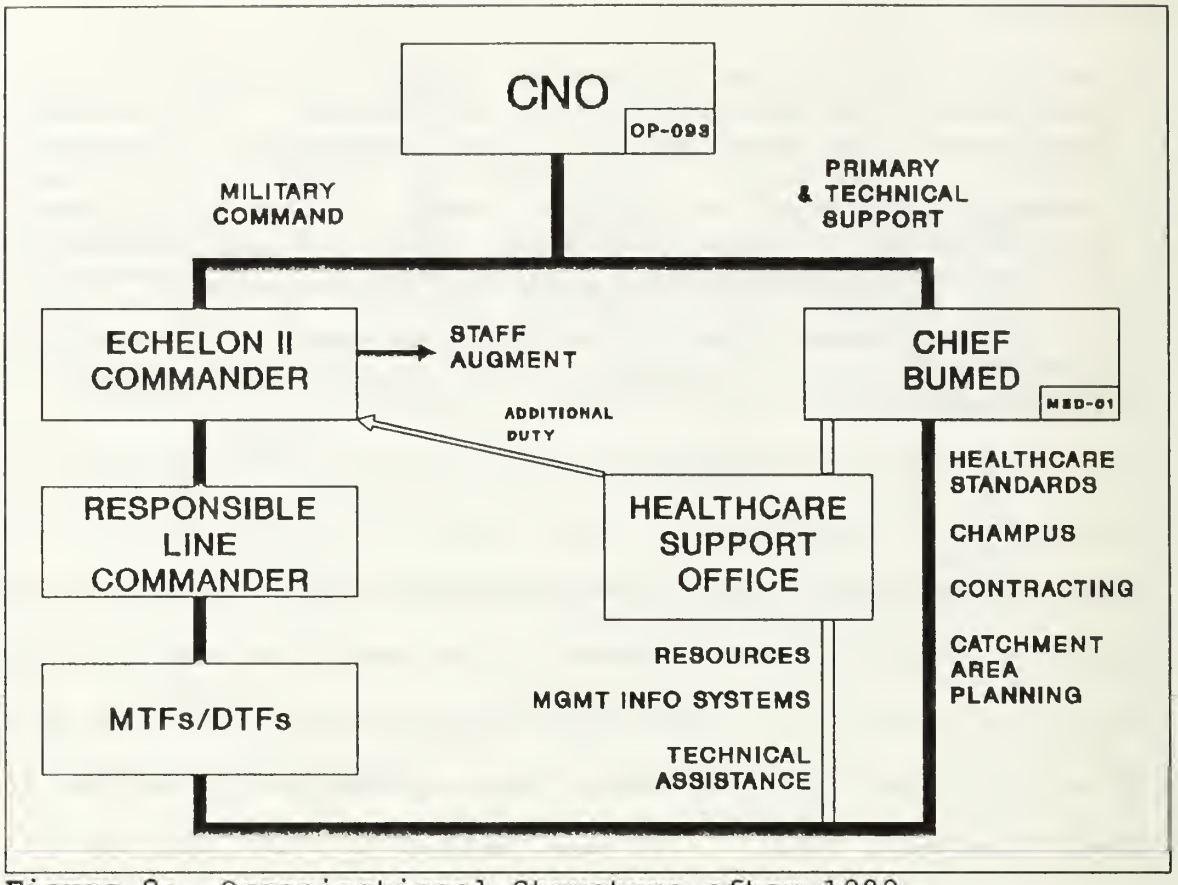

Figure 2: Organizational Structure after 1989

the MTFs/DTFs, including the direct medical/dental services function, would fall to the line and be exercised through a Responsible Line Commander (RLC), who in turn would report through the CINCs. However, Primary and Technical Support would remain with BUMED under the Surgeon General. This support would include the financial management functions of obtaining, allocating, and distributing resources.

In addition, in order to assist BUMED in absorbing functions formerly performed at the GEOCOMs, and to circumvent headquarter's manning restrictions, Healthcare Support Offices (HSOs) were created. The HSO's were intended to act as

coordinating activities for the implementation of BUMED policy at the MTFs/DTFs, without being in the direct chain-of-command between those activities and BUMED.

The new organizational structure was approved by the BRP and the Secretary of the Navy in May 1989. It was implemented on 1 October 1989 at the beginning of Fiscal Year 1990.

2. **Financial Management**

Financial management for the Medical Department is the responsibility of the Deputy Commander for Resources, MED-01, a Senior Executive Service position. As shown in Figure 1, prior to 1989, this position fell under the Commander of NAVMEDCOM. During the restructuring this position was incorporated within BUMED, (see Figure 2). All aspects of budgeting and financial reporting, including CHAMPUS, are coordinated by the MED-01 support staff.

Prior to the restructuring, all financial resources, with the exception of CHAMPUS funding, were allocated and distributed to the GEOCOMs. The GEOCOMS were Expense Limitation Holders (ELH), and in turn, issued Operating Budgets (OB) to the various activities under their control. Similarly, budget calls were issued by MED-01 to the GEOCOMS, who prepared a consolidated budget submission for their region.

Under the original BRP proposal, MED-01 would have distributed all resources, including CHAMPUS funding, to the MEDTYCOMs. This was viewed as untenable by both MED-01 and the Fleet Comptrollers from the standpoint of resource control. The input to the CNA Study from these two groups was crucial to the decision to abandon the MEDTYCOM proposal, in favor of the structure which incorporated the HSOs, and used them as a tool for resource administration.

Under the new organizational structure, MED-01 issues ELHs to the HSO's. As in the old organizational structure, CHAMPUS funding is centrally controlled. The HSOs, in turn, issue OBs to the field activities based upon specific direction from Med-01. Therefore, while the HSO's perform coordination and consolidation functions, they have no direct decision making authority over the allocation of resources to the field activities. There is a direct link in the chain-of-command between the field controllers, and MED-01.

D. IMPLEMENTATION OF THE BRP RECOMMENDATIONS

Within the Medical Department there were three primary teams which were responsible for the implementation of the BRP recommendations. These were:

- The Rapid Implementation Team (RIT)
- The Management Assist Teams (MATs)
- The BUMED Transition Team

The Rapid Implementation Team was headed by a Medical Corps Rear Admiral and was tasked with implementing the BRP recommendations at the National Naval Medical Center (NNMC), Bethesda, MD. As the premier site for navy medicine and health education, the goal of the team was to make NNMC a model medical facility for other treatment activities to emulate. This was to be done by stressing total quality management techniques, internal restructuring and streamlining, and flexible utilization of resources.

One mechanism used to spread the lessons learned from the RIT's experiences at Bethesda to the rest of the medical department was via the Management Assist Teams. The MATs were established in support of a specific recommendation of the Organization and Management Task Force of the BRP which felt that many senior medical department managers were inadequately trained in methods to judge success/failure of management techniques or to optimally allocate resources internally [Ref. 3:p. 33]. The charter of the MATs was "to provide on-site assistance and training to Navy Hospital Managers to improve their management and organizational productivity assessment skills" [Ref. 4:p. 2]. The mission of the MATs, therefore, was to assist managers of Field activities assess internal operations, and restructure those operations if required, consistent with the objectives established by the BRP for solving the longstanding problems of the Medical Department.

Beginning in February 1989, the MATs visited 20 CONUS MTFs. Based upon the success of those visits, and the positive response from the Field activities, the MAT's recommended in their final report that the MAT concept be continued and that the methodology be implemented throughout BUMED as an ongoing responsibility of the BUMED staff. Accordingly, in the new organizational structure, this assignment was tasked to the Health Service Offices.

Coordination of the MAT's findings and overall implementation within the Medical Department was the responsibility of the BUMED Transition Team. This team was composed of three members-- two active duty Medical Service Corps Captains, and one Naval Reserve officer. During the spring and summer of 1989, following approval of the new organizational structure, the Transition Team was responsible for overseeing subsequent change efforts, and reporting the progress achieved back to the BRP.

E. FOLLOW-UP ACTIONS FROM 1989 TO PRESENT

The final meeting of the Blue Ribbon Panel was held in May 1989. At that time the new organizational structure was forwarded to the Secretary of the Navy for approval. The restructuring was begun on 1 October 1989 and was scheduled for completion on 1 October 1990.

Due to the rapidity of the organizational changes and the longstanding durability of the problems facing the Medical

Department, two successor committees to the BRP were established. These were: The Flag Level Medical Working Committee (FLWC); and the Standing Medical Board (SMB). These two committees continue to track the issues and problems addressed by the BRP.

In December 1990, BUMED instigated a study of the Mission and Function of the HSOs. This study solicited input from the RLCs and MTF/DTF Commanders regarding the role, necessity, and justification for the continued existence of the HSO's. The responses from those surveyed indicated that the HSO's played a vital role in the distribution of resources and encouraged the continuation of the MAT concept. [Ref. 5:p. 3]

III. THEORETICAL FRAMEWORK

A. INTRODUCTION

In discussing the change process, Dalziel and Schoonover [Ref. 1: p. 11] describe change as a state of mind or attitude in which leadership must ask three key questions:

1. Is the organization ready?
2. Is there the right mix of skills to make the change happen?
3. Will the implementation process be successful?

This chapter presents a description of the change process compiled from current management literature which focuses on methods for answering these questions. Later chapters will use this description as a backdrop against which to view the restructuring of the Navy Medical Department.

B. THE INITIATION OF CHANGE

Change can be defined as the movement, or transition, of an organization from one state to another. The factors which stimulate that movement, and the processes by which the organization is moved have been extensively researched. Nearly every general management textbook includes a discussion revolving around the management of change and there is a large

library of volumes dealing specifically with the change process.

In her book "The Change Masters", Rosabeth Kanter, gives the following definition of change.

> Change involves the crystallization of new action possibilities (new policies, new ideas, new patterns, new methodologies, new products, or new market ideas) based upon reconceptualized patterns in the organization. The architecture of change involves the design and construction of new patterns, or the reconceptualization of old ones, to make new, and hopefully, productive actions possible. [Ref. 6:p. 279]

Similar to Ms. Kanter's definition, but in simpler terms, Deal and Bolman define change as the process by which managers "...look at old problems in a new light and attack old challenges with different and more powerful tools." [Ref. 7:p. 4]

The stimulus for change can come from a variety of sources. Primary among these are environmental factors. Again, the impact of environment on organizations has been extensively researched and discussed in management literature. Griffin presents a model which shows the organization enveloped by the external environment [Ref. 8:p. 80]. Griffin classifies the external environment into two levels, a general external environment divided into dimensions such as Sociocultural and Economic, and a task environment consisting of specific stakeholders such as regulators and customers. Each of these divisions of the external environment exerts forces on the organization which can initiate a change

process. In addition, Griffin shows the internal dimensions of the organization, such as employees, policies, and culture which can exert similar forces. Griffin's model as adapted for the Navy Medical Department is shown in Figure 3.

The organization, then, must maintain a balance between its structure and operations, and the environmental forces within and surrounding it. Beer describes this process as maintaining congruency between the organization's goals and the environment in which it exists. He writes:

> Managers redesign structure and processes in response to changes in people or the environment so that congruence

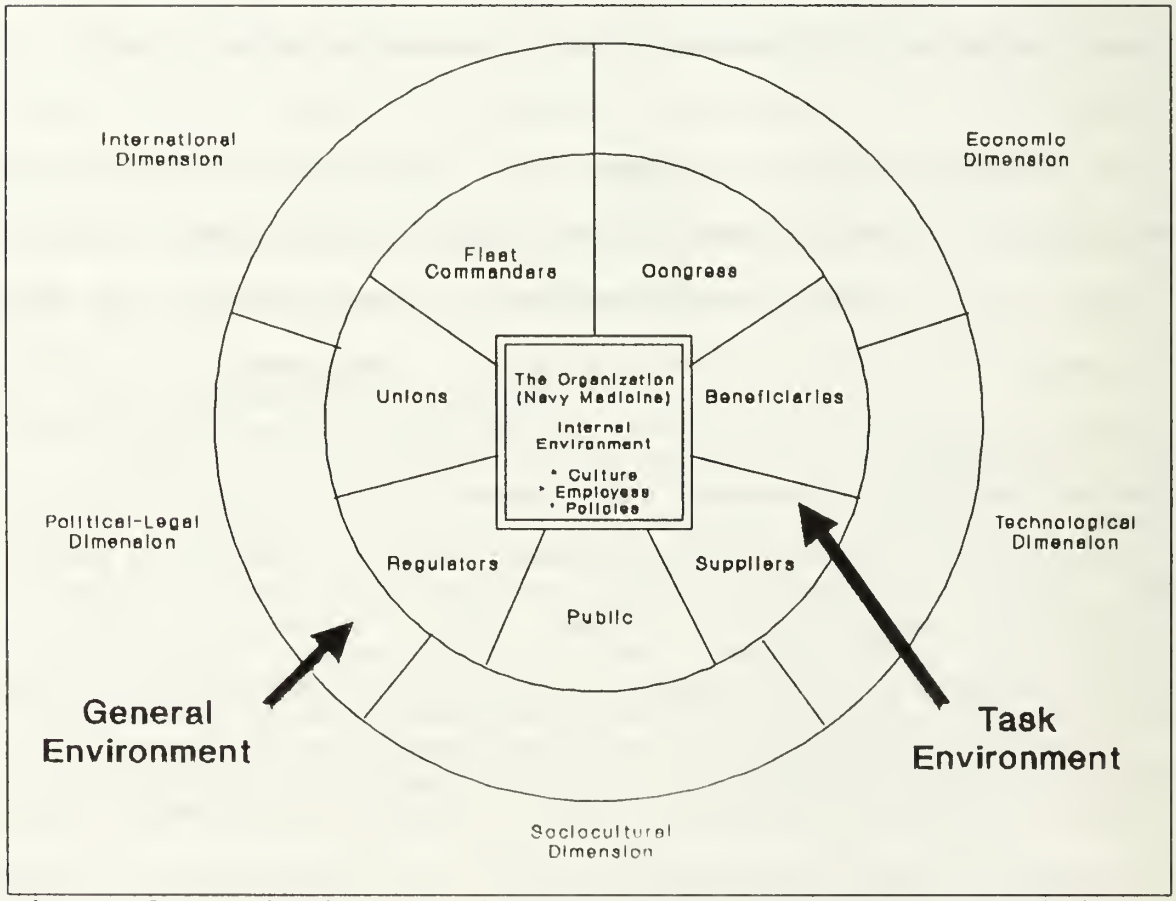

Figure 3: Griffin's Environmental Model for Navy Medicine

and effectiveness can be maintained. They may also initiate efforts to design new organizational forms, adopt new management practices, and develop people in an effort to achieve congruent patterns of people, structure, process and environment which is more effective than a former pattern. [Ref. 9:p. 6]

Kanter views this process somewhat differently and writes that "...organizational change is stimulated not by pressures from the environment, resulting in a buildup of problems triggering an automatic response, but by the perceptions of that environment and those pressures held by key actors." [Ref. 6:p. 280]

Nevertheless, whether change is viewed as resulting from real or perceived environmental pressures, change is viewed as inevitable. Griffin, citing work by Kotter and Schlesinger[3], states that most organizations must implement some change each year, with major overhauls every four to five years [Ref. 8:p. 393].

C. STRATEGY, GOALS, AND OBJECTIVES

As described by Flippo and Munsinger the thrust of most organizations is to reduce and manage the uncertainty that can result from environmental pressures [Ref. 10:p. 111]. The setting of organizational strategy, with its attendant goals and objectives, is the process used to perform this task.

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[3]. Kotter, John P. and Schlesinger, Leonard A., "Choosing Strategies for Change", Harvard Business Review, March-April 1979, p. 106.

The link between strategy and objectives is noted in the work of Alfred Chandler who defined strategy as "...the determination of the basic long-term goals and objectives of the enterprise and the adoption of courses of action and the allocation of resources necessary for carrying out these goals." [Ref. 11:p. 13] In line with Chandler, McNichols defines one aspect of strategy as an action which "...is directed toward accomplishing specific objectives." [Ref. 12:p. 3] Goals and objectives, then, are central to the operation of the organization.

The concept of an objective is defined by Hitt, Middlemist, and Mathias [Ref. 13:p. 148]. They write:

> An objective is a desired future result. It should be so formulated that in its pursuit, the organization can navigate successfully within its environment.

In their description, an objective must have the following characteristics:

- Precise and including a measured result.
- Communicated to all organizational members.
- Compatible with other objectives.

They go on to describe the purposes of objectives to:

- define the role that an organization plays in the environment.
- help decision makers to coordinate their activities.
- provide a sense of direction and serve as guides for making and implementing decisions.
- serve as standards for measuring performance.

Within the above framework it can be seen that poorly chosen, and inadequately communicated objectives can decrease management's effectiveness at dealing with environmental forces. The process for setting objectives, therefore, becomes critical. Flippo and Munsinger write:

> Organizations can not establish objectives, only people can. With organizations composed of many groups, with somewhat different goals, the determination of the set of objectives often involves conflict. [Ref. 10: p. 84]

Along this same theme, Chung writes:

> An organization as an inanimate entity does not have goals per se, but the people in it do. Organizational goals reflect the common interests of the members of the organization. To the extent that people need organizations, and vice versa, compatibility develops between the two sets of goals (personal and organizational). Conflict occurs when one group of an organization achieves its goals at the expense of another. [Ref. 14: p. 5]

Organizations, therefore, must create mechanisms to coordinate competing groups, and to link individual efforts to shared goals. According to Deal and Bolman, formal coordination and control is achieved in two ways: vertically through commands, supervision, policies, rules, planning, or control systems; and laterally through meetings, task forces, committees and matrices [Ref. 7:p. 57]. This vertical and lateral integration, therefore, can be used by organizations to establish objectives which are consistent with the strategy used to accomplish the organization's mission.

D. RELATIONSHIP OF STRUCTURE TO STRATEGY

There are many factors which can influence the shape or structure of an organization, and, in fact, restructuring is one of the most common management approaches to organizational change. Deal and Bolman describe five factors they believe most influence organizational design [Ref. 7: p. 65]. The factors they describe are:

1. Size of the Organization
2. Environment
3. Information Technology
4. Characteristics of Members
5. Goals and Strategy

McNichols writes that the design of an organization, and choice of structure, is a distinct strategic decision integral to overall organizational strategy as described by its operational and root objectives [Ref. 12:p. 479]. He supports this idea by quoting Andrews[4]:

> ... the nature of corporate strategy must be made to dominate the design of organizational structure and processes. That is, the principle criterion for all decisions on organizational structure and behavior should be their relevance to the achievement of the organizational purpose, not to their conformity to the dictates of special disciplines.

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[4]. **Andrews**, Kenneth R., The Concept of Corporate Strategy, Homewood, IL., Dow-Jones-Irwin, 1971, p. 181.

Bolman and Deal echo this relationship between strategy, objectives and organizational structure. They describe structure as follows:

> How to structure itself is one of the central issues facing any organization. A structure is more than boxes and lines arranged hierarchically on an official organization chart. It is an outline of the desired patterns of activities, expectations, and exchanges among executives, managers, employees, and customers or clients. The shape of the formal structure very definitely enhances or constrains what an organization is able to accomplish. [Ref. 7:p. 46]

Beckhard and Harris, drawing upon the work of Chandler, Galbraith and others present a view of the evolution of organizational structure theory. They state that historically, structure was defined by the reporting and control requirements of the organization. This resulted in the hierarchy or authority based models of organization. However, Beckhard and Harris postulate that as task complexity increases, authoritative organizational structures based upon communication and control requirements become less effective at the work to be performed. Instead, form should follow function. The tasks to be accomplished by an organization should be prioritized, and a structure developed to optimize overall performance of those tasks. Beckhard and Harris write that the natural evolution of structure as task complexity increases is from a functional to a mission or program oriented structure and finally, if required to a matrix structure. [Ref. 15:pp. 69-76]

Organizational structure, therefore, among the other factors listed above, is dependent upon the tasks to be performed and the objectives to be met. Changes in structure will be required as management strategy changes, and new tasks or objectives are developed in response to environmental pressures such as technology changes, political climate changes, or changes in leadership. Organizations which operate in rapidly changing or highly uncertain environments will require complex and flexible structures. [Ref. 7: p. 73]

E. MODELS FOR IMPLEMENTING CHANGE

The organizational theorist, Kurt Lewin, described the change process as occurring in three distinct steps. The first step is unfreezing the organization by leading the individuals who will be affected by the change into an understanding of why the change is necessary. The second step is actually implementing the required change. The third and final step is reinforcing the change and helping it become part of the status quo, or as Lewin describes it, refreezing the organization. Lewin's model is valuable in that it emphasizes the importance of planning, communicating, and reinforcing the change, but the very simplicity of the model limits its practical application. [Ref. 8:p. 394]

A more comprehensive model (Figure 4), is described by Griffin as a series of steps that lead from the recognition of change, through the establishment of goals, and onto

implementation and evaluation [Ref. 8:p. 394]. Curzon describes a similar comprehensive model (Figure 5), which divides the change effort into nine discrete steps [Ref. 16:p. 8]. Both authors conclude that a well defined process must be followed or the probability of failure will be high.

Like Lewin, Dalziel and Schoonover describe organizational change as consisting of three phases:preparing the organization for change; choosing the right people for effective teamwork; and implementing the right interventions to produce visible results [Ref. 1:pp. 133-145]. However,

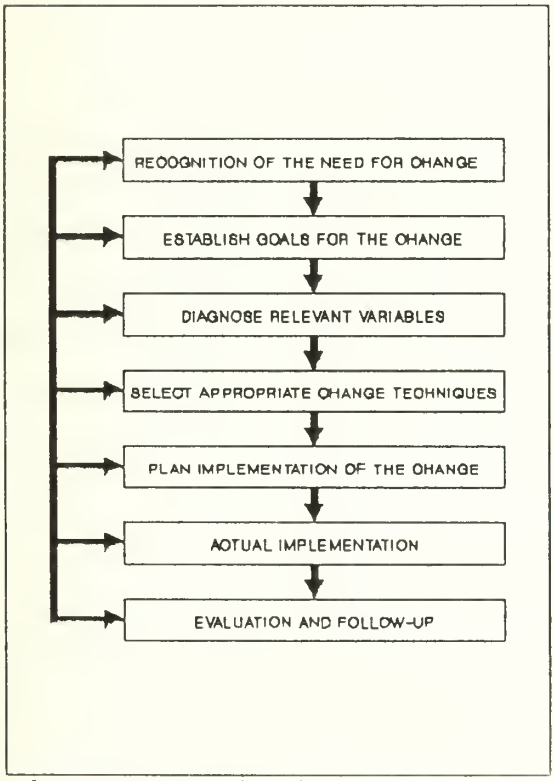

Figure 4: Griffin's Model for the Steps of Change.

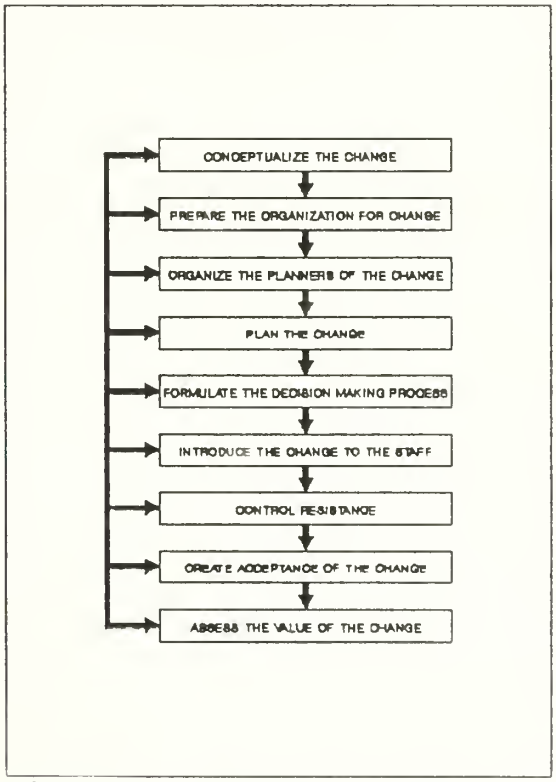

Figure 5: Curzon's Model for the Steps of Change.

they contend that these three phases must be broken into smaller series of discrete steps similar to those of Griffin and Curzon. In addition, they describe five key processes which support implementation [Ref. 1:p. 108]. These are:

1. Clarifying Plans: A process in which implementors define, document, and specify the change.

2. Integrating New Practices: The process by which change is incorporated into operations.

3. Providing Education: A process that fosters programs in which end users learn about and use new approaches and procedures.

4. Fostering Ownership: A process through which end users come to identify new processes and procedures as their own, rather than regarding them as changes imposed upon them.

5. Giving and Getting Feedback: A process in which a detailed objective is specified and input from the team is used to judge its effectiveness in the implementation plan.

The keys to all four of the models described above is that the implementation of change must proceed in an orderly fashion, beginning with extensive planning and selling of the change to the members of the organization, and ending with an extensive evaluation of the change and the implementation strategy that was used.

F. EVALUATING THE SUCCESS OF A CHANGE EFFORT

Evaluating the success of a change effort can be a slippery process, one which depends heavily on the skill and viewpoint of the evaluator. Beckhard describes several

pitfalls which can entrap the unwary evaluator. These include: failure to clarify the purpose of the evaluation; attempting to collect too much data on the change effort; and choosing the wrong time to perform the evaluation. [Ref. 15:pp. 92-98]

To avoid these pitfalls Beckhard describes an evaluation plan which should be part of the overall implementation plan of the change effort. [Ref. 15:p. 98] The evaluation plan should include the following elements:

- Clarity and agreement about the purpose or priorities of the evaluation.
- Determination of required information and selection of appropriate sources of the needed information.
- Decision about who will receive the data from the evaluation (users and feedback to sources).
- Decision on when to evaluate and selection of data-collection and analysis methods.
- Determination of resources required and available, selection of required resources, and clarification of the role of staff.

The process that Beckhard describes above is one of *how* an evaluation should be conducted and not *what* should be the determining criteria of success. In large part, those determining criteria will be based upon the type of change and the extent of the evaluation. Beckhard describes several bases for evaluating the success of a change effort. Two of these are: The Total System Performance Review; and monitoring the effects of a specific intervention. [Ref. 15:p. 87-88]

The Total System Performance review is a focus on the outcomes of the change effort. This review is based upon a comparison of the results of the change interventions with the stated organizational goals and objectives established prior to implementation. Beckhard lists the following key questions:

- To what extent has the desired condition been achieved?
- In what areas is further change required?
- What, if any, unanticipated consequences have resulted from the change effort?
- What are the current attitudes of personnel systemwide to the current condition of the organization?
- How satisfied is top management with the current, or near future condition of the organization?
- How well does the system now function in performing the organization's mission?

Monitoring a specific intervention is the evaluation of a single management action to determine if a desired outcome has been obtained, and what additional 'ripple effect' that intervention has caused in other parts of the organization. If unexpected, or undesirable reactions to the intervention have occurred, then remedial action can be taken. However, Beckhard concedes, the overall change strategy probably consists of multiple interdependent interventions, or a single intervention with multiple interrelated goals, making the evaluation of a single action problematic. [Ref. 15:pp. 92-98]

Both of these processes described by Beckhard depend upon the measurement of outcomes against stated objectives. However, as Beer describes, the quantifiable measurement of specific criteria is not the only way to evaluate the success of a change effort. Beer, who discusses change as an aspect of organizational development, judges the success of a change effort on a variety of factors largely based upon members of the organization embracing and sustaining new behaviors. He states that success can be evaluated by examining the intrinsic and extrinsic rewards offered as a result of the change effort. [Ref. 9:p. 56-57]

The first measurement of success is based upon intrinsic rewards, or "feelings' members have toward the change and the organization. Beer writes:

> In order for change to spread throughout the organization and become a permanent fixture...It is desirable but not necessary for the results of the change to be quantifiable. In fact, experience with change suggests that a direct positive experience by managers with the change may be at least as powerful, if not more powerful, than quantitative measures...Thus, direct feelings of success appear to be more important than quantifiable measures. When individuals, groups, and whole organizations feel more competent than they did before the change, this increased sense of competence reinforces the new behavior and solidifies learning associated with the change. [Ref. 9:p. 64]

Beer states, however, that intrinsic rewards are insufficient to sustain new patterns of behavior and improved performance. Extrinsic rewards, in the form of monetary, promotion, or supervisor recognition must immediately follow initial success if self-confidence and competence as a result

of the change is to be maintained. Beer states that many organizational changes fail because the organization's formal systems, peer group relationships, exercise of authority, and culture fail to support, or frustrate the new behaviors of the organization's members. [Ref. 9:p. 64]

Beer summarizes his approach by describing organizational change as a learning process which must be carefully orchestrated by the change leaders. These leaders must "articulate a new direction, consistently use symbols to communicate their vision, model desired behavior, create settings to induce desired behavior, and consistently reinforce behavior..." [Ref. 9:p. 68]

Given the difficulties of evaluating any specific change effort, a practical comprehensive model for evaluating change might be one which combines the processes described by Beckhard and Beer. This model would include a measurement of specific objective oriented outcomes, as discussed by Beckhard, and an evaluation of the change leadership, and the intrinsic and extrinsic rewards resulting from the change, as discussed by Beer.

IV. METHODOLOGY AND DATA

A. METHODOLOGY

1. Data Collection Techniques

In order to answer the primary and secondary research questions it was necessary to establish the objectives of the restructuring of the Medical Department, and to test the perceived importance of those objectives from the perspective of the target population, the Medical Department professional Financial Managers. In addition, an evaluation of the overall success of the restructuring required that data be collected regarding both the perceived effectiveness of the techniques used during the change effort, and of the perceived status of the Medical Department before and after the restructuring. The three methods used to gather this information are described below.

a. Reference Review

The first phase of research was a review of the written documentation produced during the change effort. This included reports of the Navy Inspector General, the Minutes of both the BRP and FOWG meetings, briefings presented to the BRP by NAVMEDCOM and Task Force personnel, and the final Report of the BRP. A complete listing of the documents reviewed during this phase of research is contained in Appendix C.

The purpose of this review was to obtain background knowledge required to describe the change effort and to determine the objectives and expected outcomes of the restructuring. It was also intended to define the roles and relationships of key players.

b. Interviews

Some key players identified during the reference review were interviewed either in person or by phone. These included members of the BRP Organization and Management Task Force, members of the MAT and RIT teams, senior personnel of MED-01, and a member of the Bumed Implementation Team. In order to promote frankness, all interviews were conducted on a non-attribution basis.

The purpose of the interviews was to clarify content of written references, identify objectives not explicitly stated elsewhere, test the validity of interpretations of reference material, and obtain additional insights for the preparation of the survey questionnaire.

The interviews were unstructured, focusing on the interviewee's area of expertise. However, the following specific questions were addressed during each interview.

1. What were the objectives of the restructuring?
2. What was your role in the change effort?
3. Who do you feel was the primary driving force which initiated the change process?

4. Do you feel this change effort was an attempt by the Line Navy to seize control of the Medical Department?

5. Is the restructuring going to solve the long standing problems of the Medical Department (ie: CHAMPUS, access to care)?

c. Survey Questionnaire

The final source of data was a survey questionnaire used to obtain input from the target population, which is described in Section 2 below. The survey questionnaire is included as Appendix A.

The purpose of the questionnaire was threefold:

1. Obtain quantitative perceptual data regarding:
   - Importance of objectives.
   - Achievement of objectives.
   - Relative status of specific management indicators after the restructuring.
2. Obtain quantitative data regarding perceived effectiveness of change processes used during the restructuring.
3. Obtain qualitative input regarding future change efforts.

In addition to the above, demographic information was obtained to facilitate the analysis of the survey responses.

The survey questionnaire was divided into five sections. The content and rationale for each of these sections is described below.

(1) Background Information:

This section contains the demographic data. Data were gathered in three principle categories.

1. Length and Type of Service: Used to evaluate the level of experience of the survey population and to eliminate respondents who were not part of the target population throughout the defined change period of May 88 to Aug 90.

2. Rank/Grade: Used to evaluate responses from junior and senior personnel.

3. Duty Station: Used to evaluate responses from different echelons, to track the movement of personnel between types of commands and levels, and to identify respondents who were drawing upon Out-CONUS experiences.

Responses from personnel at commands other than the headquarters activities and the MTFs/DTFs were grouped under 'OTHER' since they were not directly impacted by the majority of the structural changes to the Medical Department. Commands Out-CONUS were also somewhat outside the implementation process and structural changes due to their physical remoteness. Therefore, the data from these two groups were flagged so that their perceptions could be compared against those who were more central to the change effort.

(2) The Reorganization Process:

In this section data were collected to determine respondent's perceptions of three aspects of the change: a) evaluate the underlying causes which prompted the change effort; b) identify the principle change agents; and c) identify the means of communication used during the change effort. In addition perceptual data were obtained on the

effectiveness of both the respondent's command, and of BUMED in implementing the changes recommended by the BRP. The data gathered in this section will be used to analyze and judge the success of the change effort following the Beer model [Ref. 9] discussed in Chapter III, Section E.

(3) Objectives of the Reorganization

This section listed 16 objectives and requested an evaluation of the importance and level of achievement for each. The evaluation was based on a scale of 1 to 7 (1 = low, 7 = High), with the option of giving no opinion.

The following objectives were taken from the Final BRP report. The objective numbers correspond with the item number in the Survey Questionnaire.

1. Transfer Professional Expertise to MTFs. [Ref. 3: p. 25]

4. Improve Communication and coordination by shortening the Chain-of Command. [Ref. 3: p. 25]

7. Make GME Navy Medicine's #1 priority. [Ref. 3: p. ES-7]

8. Enhance the command/control of the Surgeon General. [Ref. 3: p. ES-14]

9. Make the Line responsible for the provision of health care. [Ref. 3: p. ES-9]

10. Create a structure for ongoing Management Assist Visits from upper echelons. [Ref. 3: p. ES-11]

11. Increase budget flexibility at the MTF's by the removal of SAG restrictions. [Ref. 3: p. 133]

16. Control/reduce CHAMPUS costs. [Ref. 3: p ES-1]

The following three objectives were drawn from the personal interviews.

6. Shield Navy Medicine from overall Defense budget cuts.

14. Minimize reorganization's impact on daily financial operations at field commands.

15. Standardize long and short range financial planning and reporting.

The remaining objectives listed below were drawn from the change literature described in Chapter III. While these objectives were not officially stated by the BRP or others interviewed, they were included in the survey to test if there were other objectives perceived by the respondents to be influencing the change effort. Objectives 2, 3, and 5 relate to the specific hierarchical structure of the medical department. Objective 12 relates to a planning strategy, and objective 13 relates to the underlying philosophy behind the change effort.

2. Decentralize authority/operations to the MTF's. [Ref. 8: pp. 292-293]

3. Centralize authority/operations at BUMED/HSOs. [Ref. 8: pp. 292-293]

5. Standardize internal organizational structure and operations at Field Commands. [Ref. 7: p. 81]

12. Establish formal mechanisms at all commands for planning and managing change. [Ref 1: pp. 13-14]

13. Stimulate creative management thinking and innovative practices. [Ref. 6: p. 19]

(4) Comparative Status of the Medical Department

This section of the survey was designed to measure the perceived impact of the restructuring on the status of the Medical Department. As discussed in Chapter III, Section E, the Beer model for evaluating the success of any change effort includes an evaluation of the intrinsic and extrinsic rewards resulting from the change effort. In a public sector organization such as the Navy Medical Department, personal extrinsic rewards are limited; however, an overall improvement in the quantity or flow of resources, or increased support from upper echelons can be classified as extrinsic rewards to the organization. Intrinsic rewards can be measured by such things as an improvement in performance, mission clarity, and overall climate.

Therefore, this section of the survey questionnaire requested an evaluation of 17 indicators, before and after the change effort. The areas evaluated covered a broad range of resource and general management responsibilities. Three areas -- access to care, control of Champus, and Line involvement -- were taken directly from the BRP report. The remaining areas were drawn from opinions expressed during interviews, and from issues addressed in the written documentation listed in Appendix C.

Each of the indicators was classified as an Extrinsic or Intrinsic reward to facilitate evaluation of the change effort utilizing the Beer model. Extrinsic rewards

were based upon some benefit accruing to the member, or his command, from an external source. The indicators representing extrinsic rewards are:

1. Fair share of DoD Resources.
2. Fair share of DoD Personnel.
5. Funding flow from BUMED to field activities.
8. Control of CHAMPUS.
10. Line involvement/responsibility for the provision of medical care.
13. Upper echelon support to field commands.

Intrinsic rewards were based upon an actual improvement in mission performance, or increased feelings of competence for the member or the command as a result of the change effort. The indicators classified as intrinsic rewards were:

3. Quality of leadership at upper echelons and field commands.
4. Organizational structure for field commands and Navy Medicine overall.
6. Access to care for beneficiaries.
7. Clarity of mission for Navy Medicine.
9. Long/short term financial planning.
11. Stability of the organizational structure of Navy Medicine.
12. Daily management of financial operations.
14. Ability of Navy Medicine to respond to internal and external forces for change.

15. Overall morale or climate within the Medical Department.

In order to minimize variations in the standard used to evaluate the impact of the change on the Medical Department, additional instructions were provided to the survey respondents. Responses were to be based upon a comparison of the two year period prior to the convening of the BRP (1986 & 1987), with conditions in 1991. Comparisons were to be based upon changes that occurred as a result of the restructuring and not from some other concurrent management initiatives.

(5) Narrative Input

This section used three questions to solicit qualitative input regarding the management of change in the Medical Department. Two specific questions dealt with mechanisms field personnel felt should be used to improve the change process. The third question addressed the implications of Total Quality Management for field level change efforts. In addition, a fourth question allowed for any additional comments the respondents wished to make regarding the 1989 restructuring, the Medical Department, or the Survey itself.

2. Survey Population Description

The population surveyed for this thesis was all Financial Management Professionals of the Navy Medical Department currently assigned as part of the medical shore

establishment who were working for the Medical Department on 30 September 1989. For the purposes of this study, members of this population had one of the following additional characteristics:

- A Medical Service Corps Officer with subspecialty code 0031 as listed on the BUPERS Fiscal Comptroller Assignment Officer Slate of 15 June 1991, or
- A U. S. Civil Service Employee, designated as the Deputy Comptroller or above on the BUMED Financial and Logistics Points of Contact List of February 1989.

Of the 175 officers listed in the BUPERS database, 25 were eliminated from the survey population because they were assigned to stations outside the Medical Department, were assigned to deployed units, or were in unidentified outservice education programs. With the inclusion of 15 Civil Service Employees, the total population surveyed numbered 165. The breakdown of the population by rank and type of duty station can be seen in Table I.

The total response rate for the survey was 69.1%, based upon 114 returned surveys. However, five of these were returned as undeliverable, and another two were from individuals who were not assigned to the Medical Department on 30 September 1989. Therefore, the response rate given the 107 useable surveys was 64.8%. A breakdown of the usable survey responses by rank and type of duty station can be seen in Table II.

TABLE I: SURVEY POPULATION CHARACTERISTICS

	O6	O5	O4	O3	O2	O1	GS	TOTAL
BUMED	1	1	5	7	4	0	3	17
HSO	2	2	2	0	2	0	2	8
MTF	2	0	14	47	4	1	0	81
DTF	0	0	1	21	1	0	0	23
OTHER	1	4	9	20	1	0	1	36
TOTAL	6	11	31	95	6	1	15	165

TABLE II: SURVEY RESPONSES (# SENT/# RETURN/% RETURN)

	O6-O4	O3-O1	GS	TOTAL
BUMED	7/ 6/ 86%	7/ 4/ 57%	3/ 1/ 33%	17/11/ 65%
HSO	6/ 6/100%	0/ 0/ 0%	2/ 2/100%	8/ 8/100%
MTF	20/22/110%	52/24/ 46%	9/ 4/ 44%	81/50/ 62%
DTF	1/ 0/ 0%	22/13/ 59%	0/ 0/ 0%	23/13/ 57%
OTHER	14/13/ 93%	21/12/ 57%	1/ 0/ 0%	36/25/ 69%
TOTAL	48/47/ 98%	102/53/ 52%	15/ 7/ 47%	165/107/65%

B. SURVEY DATA

Data collected from the usable surveys is summarized in Table B-1 in Appendix B. In order to evaluate if significant subgroup differences existed, the usable responses were stratified based upon the demographic data collected in Section I. A description of the various strata utilized is contained in Table III.

TABLE III: DATA STRATIFICATION DESCRIPTION

STRATA	DESCRIPTION	# of RECORDS
1	All Records	107
2	O4 and Above in 1989	30
2B	O4 and Above in 1991	47
3	O3 and Below in 1989	70
3B	O3 and Below in 1991	53
4	Civil Service	7
5	At Headquarters in 1989	31
5B	At Headquarters in 1991	21
6	At Headquarters in both 1989 & 1991	14
7	At Field/Other in 1989	76
7B	At Field/Other in 1991	86
8	At Field/Other in both 1989 and 1991	69
9	At Field in 1989	53
9B	At Field in 1991	63
10	At Field in both 1989 and 1991	43
11	Field/Other CONUS in 1989	60
12	Field/Other Out-CONUS in 1989	16

A one way analysis of variance (F-test) at the 95% confidence level was performed comparing each subgroup (Strata 2 - 12) with the overall summary of the data (Stratum 1). These tests showed that there were no significant statistical differences. Therefore, Stratum 1 -the total sample- will be used as the overall basis for the discussion and analysis of the data in Chapters V and VI.

While there were no overall group differences from the total sample, some specific statistically significant

differences were found when the F-test was performed comparing senior and junior personnel, and headquarters and field personnel. These differences will be addressed in Chapters V and VI as appropriate.

Despite a large movement of personnel between Headquarters, Field, and Other activities during the 1989 to 1991 period, there were no significant statistical differences between the 1989 and 1991 strata. Therefore, all data analysis will be based upon the assignment of personnel at the beginning of the change effort in 1989. In addition, no significant statistical difference was found between CONUS and Out-Conus personnel.

A student T-Test was performed for the responses evaluating Command and Bumed Effectiveness (Section II, Questions 8 and 9), and the Status of the Medical Department (Section IV). The purpose of this test was to evaluate if the ratings of effectiveness and status were significantly greater or less than the midpoint of the scale. In the case of effectiveness, this midpoint represented moderate, as opposed to low or high, effectiveness. In the case of status, this midpoint represented no change, as opposed to improvement or degradation.

Finally, the qualitative data obtained from Section V of the survey, can be found in Tables B-3 through B-5.

V. RESULTS

A. INTRODUCTION

The results presented in this chapter come from two sources: the survey questionnaire; and personal interviews. Results from the survey questionnaire are divided into quantitative and qualitative data. A summary presentation of the both the quantitative and qualitative data from the survey questionnaire can be found in Appendix B. Each section of the questionnaire is discussed separately below.

The discussion of personal interviews focuses on the answers to the five specific questions addressed during each interview as described in Chapter IV.

B. THE SURVEY QUESTIONNAIRE: QUANTITATIVE DATA

When viewed individually, the responses to the survey questionnaires displayed the broad range of opinions expected from this type of perceptual survey. Generally however, a frequency analysis of responses to each survey question which utilized a scale of response codes produced a normal or near normal distribution. Therefore, where appropriate, each of the following sections presents and discusses results for the major sections of the survey questionnaire focusing on mean values and their relationships.

1. The Reorganization Process

This section will describe the perceptions of the respondents regarding the following: the underlying factors behind the restructuring of the Medical Department; the personnel responsible and communication methods used to implement the BRP recommendations; and the effectiveness of both BUMED and the survey respondents' commands throughout the change process. These results will be used to assess the change leadership as defined by the Beer model (Chapter III, Section E).

By way of background well over three quarters of the respondents had seen or read the BRP report (Section II, Question 6). Less than half reported that their command in 1989 had established a formal planning committee or group to implement the BRP recommendations (Section II, Question 7).

a. Initiation of the change effort

As described in Chapter II, the restructuring of the Medical Department was prompted by a variety of factors. Prominent among these, according to the final report of the BRP, were the escalating costs of CHAMPUS, diminished access to care for beneficiaries, and the decline of Graduate Medical Education. [Ref. 3:p. ES-1] As shown in Table IV, the percentage of respondents who saw the first two of these factors as one of the primary driving factors behind the restructuring was each 47% (Section II, Question 1). The

TABLE IV: UNDERLYING FACTORS OF THE CHANGE EFFORT

Question (values in %)	1 All	2 Sr	3 Jr	5 Head	7 Field & Other	9 Field	11 Conus	12 Out Conus
1. Underlying Factor								
(1) CHAMPUS	47	43	50	52	45	47	42	56
(2) Line Perception	88	90	87	90	87	89	87	63
(3) GEOCOMs	44	37	46	42	45	45	47	38
(4) Defense Budget	17	13	20	6	21	26	22	19
(5) Access to Care	47	50	46	39	50	47	47	63
(6) GME	7	13	3	16	3	4	3	0

factor receiving the highest percentage (88%) was the perception by the Line of lack of control within the Medical Department. The decline of GME was perceived as a minimal factor (8%) driving the change effort.

As shown in Table V, the identification of who was the prime instigator of the change effort was not as definitive as the factors underlying the change effort (Section II, Question 2). As discussed in Chapter II, Section B, the Navy IG recommended that the CNO examine the operations of the Medical Department, whereupon the CNO convened the BRP. When all survey responses are aggregated (stratum 1), the CNO and the Navy IG are the two top choices with 37% and 21%, respectively. While this view clearly holds for higher

TABLE V: THE PRIME INSTIGATOR OF THE CHANGE EFFORT

Question (values in %)	1 All	2 Sr	3 Jr	5 Head	7 Field & Other	9 Field	11 Conus	12 Out Conus
2. Prime Instigator								
(1) SG	15	19	19	6	18	17	22	6
(2) Fleet CINCs	16	3	21	6	20	19	18	25
(3) MTF COs	3	0	1	3	3	4	3	0
(4) CNO	37	53	34	42	36	32	35	38
(5) Bene-ficiaries	7	3	9	6	7	6	7	6
(6) Navy IG	21	30	13	32	16	21	13	25

ranking and headquarters personnel (strata 2 and 5), for all other strata, the role of the Navy IG diminishes in favor of the Surgeon General and the Fleet CINCs. It should also be noted, however, that in the other strata difference between the second, third, and fourth choices is only a few percentage points. These data suggest that higher ranking, as well as headquarters personnel, have more definitive opinions resulting from increased access to higher level decision making centers and documentation that identified the roles of the IG and the CNO. Without this information, respondents located away from the headquarters of lower rank were more likely to identify the CINCs or the SG.

b. Implementation Methods

The implementation of the BRP recommendations and the daily management of the POA&M (Section II, Question 3) was the task of the BUMED Transition Team (Chapter II, Section D). The data resulting from this question are shown in Table VI. Overall (Stratum 1), the survey respondents felt that this responsibility fell primarily to the Surgeon General (31%). As the senior officer of the Medical Department, and the Commander of BUMED, the Transition Team worked directly for the Surgeon General, therefore, some respondents may have interpreted this survey question as one of ultimate responsibility vice daily responsibility. Headquarters

TABLE VI: RESPONSIBILITY FOR POA&M MANAGEMENT

Question (values in %)	1 All	2 Sr	3 Jr	5 Head	7 Field & Other	9 Field	11 Conus	12 Out Conus
3. POA&M Office								
(1) SG	31	40	29	26	33	32	27	56
(2) Fleet Cincs	6	3	7	8	8	8	5	13
(3) MTF COs	12	7	14	3	16	21	17	13
(4) MED-01	3	3	3	3	3	2	3	0
(5) MATs	9	10	10	13	8	8	10	0
(6) BUMED Team	18	23	14	29	13	13	13	13
(7) BRP	15	13	14	13	13	11	17	0

personnel (Stratum 5) were the only stratification which selected the transition team (29%) over the Surgeon General (26%). Field/Other personnel (Stratum 7) selected the SG (33%), and then the MTF Commanders (16%), over the transition team (13%). Personnel Out-CONUS (Stratum 12), overwhelmingly selected the SG (56%), and ranked the MTF Commanders (13%), and the Fleet Commanders (13%), on a par with the transition team (13%). It seems clear, therefore, that a greater distance from the headquarters, diminished the visibility of the transition team.

A wide variety of methods were used by respondents to obtain information regarding the restructuring of the Medical Department (Section II, Questions 4 and 5). As shown in Table VII, the two methods which were used most widely, and were perceived as being the most valuable, were formal written communications (74%/32%)[1] and personal contacts (64%/30%). There were no significant variations in the precedence of the methods across the various strata. However, higher ranking (Stratum 2) and headquarters personnel (Stratum 5) found greater value (40% and 52%, respectively) in personal contacts than other personnel who selected these information sources as the most valuable with a range frequency of 19% to 24%.

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[1] Throughout the text and tables of this thesis, the responses for these survey questions (Section II, Questions 4 and 5) are shown as the percentage of respondents who reported using the communication method followed by the percentage who found it the most valuable method (% used/% most valuable).

TABLE VII: USE AND VALUE OF COMMUNICATION METHODS

Question (values in %)	1 All	2 Sr	3 Jr	5 Head	7 Field & Other	9 Field	11 Conus	12 Out Conus
4. Use/Value of Info								
(1) Media	30/6	37/7	30/4	29/10	30/4	30/2	25/2	50/13
(2) BUMED Roadshow	27/8	27/10	26/7	26/3	28/11	28/13	47/19	19/13
(3) Personal Contacts	64/30	80/40	57/24	90/52	54/21	47/19	53/22	56/19
(4) MAT Visit	17/3	17/3	19/3	10/0	20/4	23/6	23/5	6/0
(5) Written Commun	74/32	80/27	74/36	65/13	78/39	77/38	78/38	75/44
(6) Internal Brief	48/21	57/10	44/19	48/29	47/17	53/21	38/20	44/6

c. Effectiveness of the Change Leadership

This portion of the survey questionnaire requested an evaluation of the effectiveness of both BUMED and the respondent's 1989 command in implementing the recommendations of the BRP (Section II, Questions 8 and 9). The scale established was from 1 through 7, with 1 representing low effectiveness and 7 representing high effectiveness. The midpoint of the scale, therefore was 4.0.

The data for this section of the survey are shown in Table VIII. The first column presents the means, standard deviations, and value of N for the total sample (Stratum 1), while the second column presents the same information for the Headquarters personnel (Stratum 5). Looking at column 1, the effectiveness of the commands was judged to be better than

TABLE VIII: MEAN RATINGS OF COMMAND/BUMED EFFECTIVENESS

MEASURE OF EFFECTIVENESS	STRATUM 1 Total Sample Sample Size = 107 N**/Mean/SD	STRATUM 5 Headquarters Sample Size = 27 N**/Mean/SD
Command Effectiveness		
Determining Objectives	89 / 4.3 / 1.72	27 / **5.1*** / 1.44
Communicating Objectives	88 / 4.0 / 1.63	27 / 4.4 / 1.70
Implementing Objectives	88 / 4.1 / 1.50	28 / **4.7*** / 1.47
BUMED Effectiveness		
Communicating Factors	97 / **3.4*** / 1.27	27 / **2.8*** / 1.06
Setting Objectives	94 / **3.6*** / 1.32	26 / 3.6 / 1.42
Communicating Objectives	94 / **3.4*** / 1.29	25 / **3.1*** / 1.21
Showing Commitment	95 / **3.6*** / 1.37	27 / 3.6 / 1.72
Gaining Commitment	94 / **3.4*** / 1.27	26 / **3.4*** / 1.38
Seeking Feedback	90 / **3.0*** / 1.28	24 / **3.0*** / 1.45
Overall Management	96 / **3.1*** / 1.16	27 / **2.8*** / 1.31

* Indicates mean effectiveness ratings that are significantly different from the midpoint rating of 4.0 ($t >= 1.96$; $p <= .05$).

** N varies for each question due to option of selecting "No Opinion".

that of BUMED in three comparable factors: a) setting/ determining the objectives; b) communicating the objectives; and c) implementing / overall management of the change effort. Utilizing the T-Test to evaluate the difference of the given means from the midpoint of the scale, the commands were perceived to be not significantly different from the midpoint of 4.0, while the effectiveness ratings of BUMED by the total sample were all found to be significantly less than 4.0 ($t >= 1.96$, $p <= .05$).

Interestingly, when isolated from the aggregate totals, data from personnel at the Headquarters activities (stratum 5) show their ratings of command effectiveness to be higher than their ratings of BUMED effectiveness. These data are shown in the second column of Table VIII. When analyzed statistically using an F-Test, this stratum was significantly different from Stratum 1 for command effectiveness, but not for BUMED effectiveness. In addition, the T-test for this stratum showed that the ratings of Command effectiveness was above or at the midpoint for the three command measures, while it was at or below the midpoint for the BUMED measures. This apparent anomaly in the perceptions of this group may have resulted from commands other than BUMED, such as the GEOCOMs, and OP-093, being included in the Headquarters stratum.

The effectiveness of BUMED was evaluated on seven factors. While acknowledging that all ratings are below 4.0, there are differences in the sample ratings of BUMED's effectiveness. The two aspects with the highest ratings were setting objectives and demonstrating commitment to the objectives each with a mean of 3.6. In contrast BUMED was less effective at seeking feedback, and the overall management of the change effort with mean ratings of 3.0 and 3.1, respectively.

2. Objectives of the Reorganization

The discussion in this section focuses on the importance and the achievement of specific objectives and is based upon the data presented in Table IX derived from responses to Section III of the survey questionnaire.

As discussed in Chapter IV, Section A1, the objectives evaluated were drawn from three sources. These were: a) The BRP final report; b) personal interviews; and c) management literature. In all, 16 objectives were presented for evaluation on a seven point scale similar to that used for evaluating the implementation effectiveness of BUMED. Table V lists the objectives, their source, the mean ratings for both importance and achievement, as well as the relative ranking of the objectives in importance and achievement.

When ranked from the most to the least important, five objectives appeared at the top of the list using the total sample. These were:

1. Transfer professional expertise to the MTF's ($\bar{X} = 4.6$).
2. Decentralize authority/operations to the MTFs ($\bar{X} = 4.5$).
4. Improve communication and coordination by shortening the Chain-of-Command ($\bar{X} = 4.4$).
6. Shield Navy Medicine from overall defense budget cuts ($\bar{X} = 4.6$).
16. Control/reduce CHAMPUS Costs ($\bar{X} = 4.4$).

TABLE IX: RANKING OF OBJECTIVES BY IMPORTANCE AND ACHIEVEMENT

Objective	Source	Importance N*/Mean/SD	Rank	Achievement N*/Mean/SD	Rank
1. Pers shift	BRP Report	89/ 4.6 /1.68	2	94/ 3.6 /1.66	7
2. Decen-tralize	Liter-ature	100/ 4.5 /1.71	4	97/ 3.6 /1.40	8
3. Centralize	Liter-ature	101/ 3.6 /1.63	15	95/ 4.0 /1.46	2
4. Chain-of-Command	BRP Report	103/ 4.4 /1.77	5	101/ 2.9 /1.37	15
5. Standard structure	Liter-ature	102/ 4.1 /1.80	10	99/ 3.0 /1.33	10
6. Shield budget	Inter-views	102/ 4.6 /1.85	3	100/ 3.8 /1.66	4
7. GME #1 Priority	BRP Report	100/ 4.0 /1.66	11	91/ 4.0 /1.83	1
8. SG Command & Control	BRP Report	100/ 4.2 /1.63	9	97/ 3.7 /1.54	5
9. Line Resp for Care	BRP Report	102/ 4.0 /1.89	12	101/ 3.0 /1.39	14
10. MAT Visits	BRP Report	99/ 3.5 /1.48	16	95/ 3.0 /1.47	13
11. Budget Flex	BRP Report	102/ 4.2 /2.01	7	100/ 3.9 /1.88	3
12. Planning	Liter-ature	100/ 4.0 /1.73	13	98/ 3.0 /1.36	12
13. Creativity	Liter-ature	103/ 4.2 /1.91	8	101/ 3.3 /1.44	9
14. Minimum Impact	Inter-views	103/ 4.2 /1.73	6	100/ 3.6 /1.58	6
15. ST/LT Planning	Inter-views	103/ 4.2 /1.73	6	100/ 3.0 /1.38	11
16. CHAMPUS	BRP Report	101/ 4.7 /2.03	1	98/ 2.7 /1.28	16

* N varies for each question due to option of selecting "No Opinion".

Across the various strata there was only one statistical difference from the above list. Headquarters personnel, (stratum 5), did not include objective 6 as one of the top five objectives. Instead, Objective 8, "Enhance the Command/Control of the SG" (mean = 4.1), was in the top five list.

Three of the top five objectives were drawn from the final report of the BRP. These were objectives 1, 4, and 16. Of the five additional objectives drawn from the report, two were ranked in the middle third, while three ended up near the bottom of the list. Included in the bottom third of the list was objective 7, "Make GME Navy Medicine's #1 priority", objective 9, "Make the Line responsible for the provision of medical care", both with means of 4.0, and objective 10, "Create a structure for ongoing Management Assist Visits from upper echelons" with a mean of 3.5.

Ranking the objectives based upon perceived level of achievement produces a list markedly different than when ranked upon perceived importance. Based upon the aggregation of all records, (there were no significant statistical variations for any subsample), the top five objectives for achievement are as follows:

3. Centralize Authority /operations at BUMED/HSOs ($\bar{X}$ = 4.0).

6. Shield Navy Medicine from overall defense budget cuts ($\bar{X}$ = 3.8).

7. Make GME Navy Medicine's #1 priority ($\bar{X}$ = 4.0).

8. Enhance the command/control of the SG ($\bar{X}$ = 3.7).

11. Increase budget flexibility at the MTF's by the removal of SAG restrictions ($\bar{X}$ = 3.9).

The composition of this list brings to light several significant differences between perceived importance and achievement. First, only objective 6, shielding the budget, is common to the two top five lists. In addition, two of the remaining four objectives on the achievement list, ranked in the bottom third in importance. Conversely, two of the top five objectives in importance, rank in the bottom third in achievement. These two findings suggest either limited attention has been placed on implementing important objectives, or that the more important the objective, the more difficult it is to achieve. Third, it is interesting to note that while decentralization was overwhelmingly perceived as more important than centralization, the opposite is true for achievement where it was perceived that more centralization than decentralization has been achieved.

3. Comparative Status of the Medical Department

As discussed in Chapter IV, section A1, the purpose of this portion of the survey questionnaire was to obtain an evaluation of the perceived status of the Medical Department based upon a list of management indicators. Respondents were requested to evaluate the status of each indicator today,

compared with the two year period prior to the convening of the BRP. Again a scale of 1 - 7 was utilized. In this case a score of 7 indicated the respondent thought the Medical Department was better off, while a score of 1 indicated the Medical Department was worse off. The midpoint of the scale, 4.0, indicated that no change in status had occurred.

The results for this section of the survey are shown in Table X. To statistically evaluate the data, all means were compared with the midpoint on the scale (4.0), which represented no change in status, using a student's T-Test. Only two factors (1 and 4b) showed a statistically significant increase in status. Specifically these were "receiving a fair share of DoD resources" and the "leadership quality at field activities."

Four factors (4a, 8, 9, and 11) showed a statistically significant decrease. Factors 4a and 8, "Organizational Structure of Navy Medicine" and the stability of that structure, are particularly noteworthy since they reflect directly on the primary strategy of the change effort. In addition, the decrease of factor 8, "Control of CHAMPUS", also demonstrates a perceived lack of success of the change effort at addressing one of the primary underlying factors which respondents perceived to be the cause of the change effort.

All of the remaining factors evaluated were rated as unchanged. Included in this group was another of the primary driving forces respondents perceived to be the cause of the

TABLE X: COMPARATIVE STATUS OF THE NAVY MEDICAL DEPARTMENT

Management Factor	Total Sample Sample Size = 107 N**/Mean/SD
1. Share of DoD Resources	93 / **4.5*** / 1.20
2. Share of DoD Personnel	93 / 4.2 / 1.24
3. Leadership Quality	
(a) Upper Echelon	97 / 4.1 / 1.16
(b) Field Commands	95 / **4.3*** / 1.15
4. Organization Structure	
(a) Navy Medicine	96 / **3.7*** / 1.33
(b) Field Commands	97 / 3.9 / 1.27
5. Funding Flow to Field	96 / 3.9 / 1.40
6. Access to Care	95 / 4.1 / 1.06
7. Clarity of Mission	96 / 4.0 / 1.22
8. Control of CHAMPUS	96 / **3.4*** / 1.29
9. LT/ST Fin Planning	95 / **3.7*** / 1.38
10. Line Responsibility	95 / 4.2 / 1.31
11. Org Stability	95 / **3.4*** / 1.28
12. Daily Management	97 / 4.0 / 1.24
13. Upper Echelon Support	97 / 3.8 / 1.23
14. Change Response	98 / 3.8 / 1.28
15. Overall climate	98 / 3.9 / 1.35

* Indicates mean status ratings that are significantly different from the midpoint rating of 4.0 ($t >= 1.96$, $p <= .05$).

** N varies due to option of selecting "No Opinion"

change effort, "Access to care for beneficiaries", and one of the major restructuring strategies, "Line involvement and responsibility for the provision of medical care". In addition, the ability of Navy Medicine to respond to future

change efforts (factor 14), and the overall climate of the Medical Department (factor 15), also were rated unchanged.

In this section of the survey there were some significant statistical differences between the strata (Table XI). Senior and junior personnel (strata 2 & 3) differed on the status of three indicators (4a, 11, and 13). These were: "Organizational Structure of Navy Medicine"; "Stability of the Organizational Structure"; and "Upper Echelon Support to Field Commands". In all three cases, senior personnel perceived a decrease in status, while junior personnel felt that these indicators remained the same. In addition, Headquarters personnel, (stratum 5), perceived a decrease in indicator 4A and 11, while Field personnel (stratum 9) felt that these indicators remained the same. Taken together, these two

TABLE XI: COMPARATIVE STATUS OF THE NAVY MEDICAL DEPARTMENT, SELECTED STRATA

Management Indicator	Stratum 2 Senior Pers Sample = 30 N**/Mean/SD	Stratum 3 Junior Pers Sample = 70 N**/Mean/SD	Stratum 5 Headquarters Sample = 27 N**/Mean/SD	Stratum 9 Field Sample = 53 N**/Mean/SD
4A. Leadership Quality at Upper Echelons	27/ 3.1* /1.12	62/ 4.1 /1.24	29/ 3.2* /1.40	46/ 3.9 /1.29
11. Structural Stability	28/ 2.9* /1.31	60/ 3.8 /1.16	30/ 2.9* /1.35	44/ 3.67 /1.25
13. Support to Field from Upper Echelons	27/ 3.3* /1.59	63/ 4.0 /1.01	29/ 3.6 /1.52	47/ 3.9 /1.18

* Indicates mean status ratings that are significantly different from the midpoint rating of 4.0 ($t >= 1.96$, $p <= .05$)

** N varies due to option to select "No Opinion"

variations between the strata seem to indicate a greater degree of pessimism regarding the restructuring strategy of the change effort from higher ranking personnel and those more central to the implementation process. One possible explanation for this finding is that more senior personnel have personal experiences with the earlier, and unsuccessful, Medical Department restructurings, which are unfavorably coloring their view of the 1989 effort. While there is some evidence to support this explanation in the form of specific statements in the qualitative portion of the survey questionnaire, any conclusions based upon this evidence would be highly speculative.

C. THE SURVEY QUESTIONNAIRE: QUALITATIVE DATA

Qualitative data was requested regarding the management of change in the Medical Department. Two specific questions dealt with mechanisms which should be used to improve the change management process. A third question addressed the integration of Total Quality Leadership (TQL) into field level change efforts. A final question allowed for any additional comments the respondents wished to make regarding the 1989 restructuring, the Medical Department, or the Survey itself. The specific survey questions can be found in Appendix A.

Overall, 70% of the respondents answered one or more of the first three questions, while 30% provided additional

comments. A summary of the responses for questions 1 - 3 can be found in Appendix B, Tables B-2 through B-4.

Question 1 centered on the best method for field personnel to provide input to the change process. Most respondents interpreted this question from a purely communications standpoint. A variety of communications techniques were proposed including: Annual Financial Management Conferences; Point Papers; and Electronic Mail. A generic requirement for open lines of communication was mentioned by 16% of the survey respondents answering the question.

Several respondents also suggested process changes including: field participation on the IG Team; a separate BUMED Division, staffed by field representatives, for the centralized control of communications between the field and BUMED; and reestablishment of the GEOCOMs.

Question 2 focused on TQL and the change process for field activities. Interestingly, the two most frequent responses are contradictory. Adopting TQL as a "way-of-life" was mentioned 11 times, while the sentiment that TQL will never work in the Medical Department was mentioned 10 times. This second sentiment was augmented by an additional 9 comments that TQL will never work for the field activities until it is fully embraced and practiced by BUMED itself.

Question 3 requested specific mechanisms or processes the Medical Department should utilize to face future forces for change. This question provoked the widest range of responses

of any of the four questions in this section. Again, like question 1, many of the responses focused on communication issues. In addition, 10% of the answers suggested eliminating BUMED from the change process by enhancing the connection between field activities, and the Line Navy.

Other comments provided in response to question 4 focused primarily on amplifications of answers to other questions, generalized comments on the restructuring as a whole, or on the survey itself. Where appropriate, these comments have been incorporated into Tables B-2 through B-4. In addition, four people, although carrying a Financial Management subspecialty code, stated that they felt they were either unqualified to respond to the survey questions, or had little or no knowledge of the 1989 restructuring even though they had financial management positions during the target period.

D. PERSONAL INTERVIEWS

As discussed in Chapter IV, Section A, the purpose of the personal interviews was primarily to clarify content and interpretations of written references, identify objectives, and obtain additional insights for the preparation of the survey questionnaire. The personnel interviewed included members of the BRP Organization and Management Task Force, senior personnel in MED-01, a member of the Bumed Transition Team, as well as members from the IIAT and RIT teams.

The interviews were unstructured, focusing instead on the member's area of expert knowledge regarding the change effort. However, the following specific questions were addressed during each interview.

1. What were the objectives of the restructuring?
2. What was your role in the change effort?
3. Who do you feel was the primary driving force which initiated the change process?
4. Do you feel this change effort was an attempt by the Line Navy to seize control of the Medical Department?
5. Is the restructuring going to solve the long standing problems of the Medical Department (ie: CHAMPUS, access to care)?

The interviews provoked one of two responses to question 1. Either the interviewee referred to the final report of the BRP for a list of objectives, or it was stated that the restructuring had no objectives. From these two positions additional probing usually revealed additional objectives not formally stated in the BRP report. Three of these were included in the survey questionnaire and are described in Chapter IV. Other opinions in response to this question were used to frame the management indicators utilized in Section IV of the survey questionnaire.

In response to question 3, all interviewees referred to either the memorandum of the Navy IG [Ref: 2], or selected the CNO as the prime instigator of the change effort. In addition all interviewees felt the change effort was initiated in

response to pressures from the Line and Beneficiaries to improve access to care, and reduce CHAMPUS costs. Over half of the interviewees also listed the apparent lack of command and control by the Surgeon General as a major force behind the change effort.

Only one member felt that the restructuring was a direct attempt by the Line to gain control of the Medical Department. A majority of the remaining members felt that the Line did not want control of Navy Medicine and opposed the restructuring and the resulting dual chain-of-command.

Most interviewees felt that it was too early to fully determine the impact of the restructuring on the long standing problems of the Medical Department (CHAMPUS, Access to care, etc.). However, several members felt that the restructuring was not directed at the true underlying causes of the Medical Department's problems such as quantity of resources and lack of clarity of mission, but rather, as with earlier reorganizations, attempted to treat symptoms of the basic causes, such as command and control and communication issues, through structural remedies. As a result, they felt that the 1989 restructuring will ultimately fail. In support of this position, these members pointed to the ongoing controversy regarding the new chain-of-command and continuing efforts to evaluate the role of the RLC's and the HSO's [Ref. 5].

VI. CONCLUSIONS

A. EVALUATING THE 1989 RESTRUCTURING

As Beckhard warns there are many pitfalls which can entrap the unwary evaluator [Ref. 15]. These include the timing of the study and the sources of the information upon which the evaluation is based. In addition, the confines of the evaluation must be clearly stated at the outset. This thesis uses the change management and evaluation models described in Chapter III to evaluate the success of the 1989 restructuring of the Navy Medical Department from the perspective of the Financial Management professionals of the Department.

While the use of these models will fulfill the requirements of the primary thesis research question, it must be noted that the change effort being evaluated is not yet complete. Some interviewees and survey respondents expressed this concern, and in fact, pointed out that any evaluation based upon achieving specific objectives is premature. However, the history of the Medical Department reveals that the time span between major reorganizations is decreasing, and documentation reviewed during background research revealed that formal management initiatives have already begun to refine or reverse many of the restructuring initiatives of 1989 [Ref 5]. Therefore, the conclusions presented in this

chapter will focus on specific measures of success or failures, and how these can influence future change efforts.

It must also be noted that although the Financial Management community is a central part of the management of Navy Medicine, it is by no means the definitive component. This population was selected, however, because many of the problems facing Navy Medicine today are resource related issues. Therefore, any action taken to address those problems, must to a large degree, be facilitated by the actions of the resource managers.

B. CHANGE MODELS

1. The Griffin and Curzon Models

As discussed in Chapter III, and illustrated in Figures 4 and 5, Griffin and Curzon provide a sequence of steps for the management of a change effort. Both conclude that a well defined process must be followed or the probability of successfully implementing the change will be low.

In both models, the Blue Ribbon Panel fulfills the requirement for a well defined change process. However, the BRP was only tasked with completing the first few steps in either model.

In the case of Griffin's model, the BRP completed the first four steps: Recognizing the need for change; Establishing goals for the change; Diagnosing the relevant

variables; and Selecting the appropriate change techniques. The remaining steps were all tasked to BUMED and were managed by the transition team.

Curzon's model is somewhat harder to interpret for a large scale change effort, but again, the BRP appears to have been tasked with about half of the defined steps. The first three steps, conceptualizing the change, preparing the organization for change, and organizing the planners of the change seem to lie fully within the scope of the BRP. The next two steps, planning the change, and formulating the decision making process seemed to be shared responsibilities with BUMED. The remaining steps were tasked fully to BUMED.

2. **The Beckhard Model**

Beckhard describes the Total System Performance Review as the comparison of stated organizational goals and objectives with change outcomes. In order to perform this comparison, Beckhard assumes that a clearly stated set of objectives was prepared prior to the initiation of the change effort.

As discussed in Chapter III, this development of objectives, or a vision of success for the new organization, is one of the first critical steps for managing change successfully. However, personal interviews with principle change agents and personnel at Headquarters activities

revealed that no specific list of objectives was prepared for this change effort.

The BRP report, while listing numerous recommendations for specific management actions, only cited three major goals of the reorganization. These were to reduce the use and cost of CHAMPUS, increase access to care, and make GME Navy Medicines #1 priority. In all three cases, these objectives failed to meet the criteria established by Hitt, Middlemist, and Mathias that an objective must have a precise and measurable result.

Although the survey respondents clearly shared the view that the control of CHAMPUS was a driving force behind the change, and that it was a top objective of the restructuring, the importance of GME was not clearly communicated to the survey population. This is evidenced by the low ranking the GME objective was given by the survey respondents.

According to Beckhard, and the other change management models cited (i.e., Griffin, Curzon), this lack of emphasis on the creation and communication of objectives was a major failing in this change effort. As a result, the determination of objectives was left to the personal interpretation of the implementation teams and the target population. As shown by the survey data, although there was a strong agreement on the importance and achievement of objectives, there was not necessarily congruence between the goals as perceived and the

goals and recommendations as stated by the BRP. This resulted in the perceived importance of objectives not addressed by the BRP, and the achievement of objectives not central to the success of the change effort.

In addition to the achievement of specific objectives, the Beckhard model also requires an evaluation of the current attitudes of the personnel impacted by the change regarding the current condition of the organization. As demonstrated by Section IV of the survey questionnaire, for nearly all management indicators, the survey population feels the Medical Department is no better off than it was before the change effort was begun.

Based upon the lack of congruence between the respondents' perceived objectives and the BRP's stated goals, and the lack of measurable performance improvements, the Beckhard model suggests that the 1989 restructuring was not successful.

3. The Beer Model

This model, discussed in Chapter III, focuses on the change leadership, and on intrinsic and extrinsic rewards in evaluating the change effort. Unlike the Beckhard model, Beer states that what may be more important than the achievement of specific objectives are feelings of success as a result of the change. These affective responses can lead to increased competence and reinforcement of new behavior. [Ref 9]

The Beer model begins with an evaluation of the leadership of the organization during the change effort. Beer states that the leadership must demonstrate commitment, seek feedback, and generally support the change effort if it is to be successfully implemented by other members of the organization.

The survey population clearly felt that BUMED was, at best, only moderately effective at managing the change process as demonstrated in Section II of the questionnaire. The reported data could be the result, however, of a number of alternative explanations.

The first alternative explanation is that there is a general feeling of disdain for BUMED. The qualitative data generated by Section V of the survey show a broad based antipathy directed at BUMED, and that there were wide divisions between field and Headquarters personnel. This could account for a general tendency to rank BUMED effectiveness low.

A second alternative explanation is that there are major communications problems in the Medical Department. The qualitative data also indicate that respondents perceived revised or enhanced communications procedures as principle methods to improve the change process. Since most of the BUMED effectiveness factors were contingent upon communication between BUMED and the Field commands, perceived communication problems would result in lower effectiveness ratings.

A third alternative explanation is that BUMED's effectiveness at leading the implementation effort really was poor. This could be due to the restraints placed upon BUMED by the BRP, the implementation methods chosen, or the lack of time and personnel resources to fully plan and carry out a successful implementation strategy.

Regardless of whether one, some, or all of the above explanations are judged to be correct, the Beer model would suggest that the organization leadership during the change effort has not been successful. If successful change leadership had occurred, the general antipathy directed at BUMED, and the related communications problems, might have been neutralized, and hence resulted in higher effectiveness ratings across the seven measures utilized.

The second portion of the Beer model is a measure of the intrinsic and extrinsic rewards which accrued as a result of the change effort. As discussed in Chapter IV, the extrinsic rewards, as defined by Beer, available to public sector employees, particularly military members, are limited. However, such things as an increased flow of resources, or an increase in support from upper echelons to an organization, could be viewed as an extrinsic reward to the organization. These factors were measured in Section IV of the survey. One extrinsic reward, the share of DoD resources allocated to Navy Medicine, had clearly improved in the view of the survey population. This was balanced however, by a decrease in

another extrinsic reward, the control of CHAMPUS. Intrinsically, all factors, with the exception of quality of command leadership, either remained the same, or decreased.

The picture that is painted with the Beer model, then, is a change effort that has been largely unsuccessful due to the perceived ineffectiveness of the change leadership, and the perceived lack of rewards resulting from the change process.

4. A Summary Evaluation

When taken together, the Beckhard and the Beer models provide an overall evaluation based on three criterion. These are: 1) the comparison of stated objectives and perceived outcomes; 2) the effectiveness of the change leadership; and 3) the perceived change in the organization's performance as measured by the members feelings regarding the organization and the rewards accrued during the change effort. As discussed above, the restructuring of the Medical Department has been unsuccessful based upon all of these criterion as perceived by the Financial Management professionals within Navy Medicine.

Within the framework of the Griffin and Curzon models it seems clear, therefore, that the change process was disrupted at some point since the outcomes established, or conceptualized at the beginning of the process, were not the same as the perceived results. This study was not designed to

specifically evaluate each step as defined by Griffin and Curzon. However, the BRP process did produce a set of recommendations and the framework of a new organizational structure in the final report of November 1988. In addition, BUMED did create a specific implementation plan which was initiated from May 1989 until the present. The breakdown in the process, then, appears to be the result of decisions that were made after the BRP report was completed and prior to the formal restructuring on 1 October 1989. A more definitive study which formally evaluates the steps in the change process is required to fully delineate the extent to which this change effort departed from the Griffin and Curzon models.

There are elements of success, however, within the scope of the change models utilized. Although there was a breakdown in the development and communication of objectives from the BRP to the Field activities as measured within the Beckhard model, a consensus on the importance of specific issues, such as CHAMPUS was achieved. In addition, while most members saw very little improvement in the status of the Medical Department as a result of the change, there was a very positive feeling that the resources of Navy Medicine were being protected from the overall defense budget cuts as a result of the restructuring. Members at field activities also saw an improvement in the quality of leadership of their commands. It is possible that these elements of success, could be the crucible for a future successful change effort.

C. IMPLICATIONS OF THIS STUDY FOR FUTURE CHANGE EFFORTS

What emerges from this study is that there is a broad consensus, within the Financial Management community of what is and is not important to the future of Navy Medicine, and that the restructuring of the Medical Department has not been successful at addressing the basic underlying problems of the Medical Department. What emerged from the Blue Ribbon Panel process, therefore, was a top down statement of strategic purpose, which was not fully embraced during the implementation process due to a failure in the communications between the strategic planners, the upper level implementors, and the field activities.

The results of this study indicate that major revisions in the strategic development and implementation of change are required. First, a clear set of objectives or vision of success must be established by the change leadership directed toward solving the basic underlying problems of the Medical Department. Second, once developed, those objectives must be widely disseminated and used as the basis for both Headquarters and Field level implementation strategies. Third, for system wide changes, Field level personnel must be brought into the change process at the very beginning, and must remain in the process until the implementation phase is completed. This would enhance the commitment of the Field personnel to the change process, and help clarify and define the rewards accruing from the change effort. Taken together,

these revisions increase the likelihood of a successful implementation.

The data collected in this study show that despite a massive restructuring, and the consumption of resources, the Medical Department is, overall, no better off today than prior to this change effort. However, as measured by the Beckhard and Beer models, the quantitative margin between the apparent failure of the restructuring and potential success is small. Had the revisions discussed above been included in this change effort, the two models might have reported success instead of failure.

Finally, the BRP was the third major effort in the last 20 years to address the underlying problems of the Medical Department through structural changes. While the BRP report is not limited strictly to structural recommendations, an enormous amount of energy was directed at structural solutions. What is clear from the results of this study, is that it is time for Navy strategic planners to look beyond structural changes as the solutions to major strategic issues.

APPENDIX A. THESIS SURVEY QUESTIONNAIRE

SECTION I Background Information:

1. How many years have you been in Government Service? _____
2. How many years have you been a Navy Financial Manager? _____
3. Were you working for the Navy Medical Department on 30 Sep 1989? _____

4. Rank/Grade:

	30 Sep 1989		Today
(1) _____	O4 and Above	_____	O4 and Above
(2) _____	O3 and Below	_____	O3 and Below
(3) _____	GS-12 and Above	_____	GS-12 and Above
(4) _____	GS-11 and Below	_____	GS-11 and Below

5. Duty Station:

	30 Sep 1989		Today
(1) _____	NAVMEDCOM	_____	BUMED
(2) _____	GEOCOM	_____	HSO
(3) _____	Hospital/Clinic	_____	Hospital Clinic
(4) _____	Dental Clinic	_____	Dental Clinic
(5) _____	Other	_____	Other

6. Were you Out-CONUS in 1989? _____ Are you Out-CONUS now? _____

SECTION II The Reorganization Process:

1. From the choices given, which do you feel were the primary underlying factors which prompted the reorganization? (Select 3 or less)

(1) _____ Growth of CHAMPUS
(2) _____ Line perception of lack of control within Navy Medicine
(3) _____ Dysfunctional Operation of the GEOCOM's
(4) _____ Overall decline in the Defense Budget
(5) _____ Diminished access to medical care for beneficiaries
(6) _____ Declining Graduate Medical Education

2. From the choices given, who do you feel was the primary instigator of the 1989 reorganization? (Choose one)

(1) _____ The Surgeon General
(2) _____ The Fleet Commanders
(3) _____ The MTF Commanders
(4) _____ The Chief of Naval Operations
(5) _____ The Beneficiary Population
(6) _____ The Navy Inspector General

3. Who had the daily responsibility for the development and implementation of the plan of action for the Blue Ribbon Panel recommendations? (Choose one)

(1) _____ The Surgeon General
(2) _____ The Fleet Commanders
(3) _____ The MTF Commanders
(4) _____ MED-01
(5) _____ The Management Assist Teams
(6) _____ The Bumed Transition Team
(7) _____ The Blue Ribbon Panel itself

4. From the list below, indicate how you obtained or received information regarding the reorganization. (select as many as appropriate)

(1) _____	Media	(4) _____	Management Assist Team Visit
(2) _____	NAVMEDCOM Roadshow	(5) _____	Official Written Communications
(3) _____	Personal Contacts	(6) _____	Internal Command Briefings

5. Which single method above was the most valuable for you? _____

6. Have you seen/read the Blue Ribbon Panel recommendations (Y/N)? _____

7. Did your command in 1989 have/establish a committee, task force, or other planning group to implement the reorganization (Y/N)? _____

8. How effective was your command in 1989 at the following: (Indicate by placing an "X" on the scale)

	Very 7 6	Moderate 5 4 3	Little 2 1	No Opinion 0
(1) Determining the reorganization's objectives for Navy Medicine.	|---|---|	|---|---|---|	|---|---|	-|-
(2) Communicating those objectives within your command.	|---|---|	|---|---|---|	|---|---|	-|-
(3) Implementing the objectives within your command.	|---|---|	|---|---|---|	|---|---|	-|-

9. How effective was BUMED at the following: (Mark the scale with an "X")

	Very 7 6	Moderate 5 4 3	Little 2 1	No Opinion 0
(1) Communicating the underlying factors driving the reorganization.	|---|---|	|---|---|---|	|---|---|	-|-
(2) Setting the reorganization's objectives for Navy Medicine.	|---|---|	|---|---|---|	|---|---|	-|-
(3) Communicating those objectives to the field activities.	|---|---|	|---|---|---|	|---|---|	-|-
(4) Showing commitment to the objectives.	|---|---|	|---|---|---|	|---|---|	-|-
(5) Gaining commitment for the objectives from field activities and the Line.	|---|---|	|---|---|---|	|---|---|	-|-
(6) Seeking feedback from the field activities and the Line.	|---|---|	|---|---|---|	|---|---|	-|-
(7) Overall management of the change process.	|---|---|	|---|---|---|	|---|---|	-|-

SECTION III. Objectives of the Reorganization:

Part A: Below is a list of possible objectives. Indicate how important you feel these objectives were to the 1989 reorganization. (Mark scale with an "X")

	OBJECTIVE	IMPORTANCE High 7	6	Moderate 5	4	3	Little 2	1	No Opinion 0
1.	Transfer professional expertise to MTF's.	|	|	|	|	|	|	|	-|-
2.	Decentralize Authority/Operations to MTF's.	|	|	|	|	|	|	|	-|-
3.	Centralize Authority/Operations at BUMED/HSO's.	|	|	|	|	|	|	|	-|-
4.	Improve communication and coordination by shortening the Chain-of-Command.	|	|	|	|	|	|	|	-|-
5.	Standardize internal organizational structure/operations of Field Commands.	|	|	|	|	|	|	|	-|-
6.	Shield Navy Medicine from overall Defense budget reductions.	|	|	|	|	|	|	|	-|-
7.	Make GME the Navy Medicine's #1 priority.	|	|	|	|	|	|	|	-|-
8.	Enhance the command/control of the Surgeon General.	|	|	|	|	|	|	|	-|-
9.	Make the Line responsible for the provision of medical care.	|	|	|	|	|	|	|	-|-
10.	Create a structure for ongoing Management Assist Visits from upper echelons.	|	|	|	|	|	|	|	-|-
11.	Increase budget flexibility at the MTF's by the removal of SAG restrictions.	|	|	|	|	|	|	|	-|-
12.	Establish formal mechanisms at all commands for planning/managing change.	|	|	|	|	|	|	|	-|-
13.	Stimulate creative management thinking and innovative practices.	|	|	|	|	|	|	|	-|-
14.	Minimize reorganization's impact on daily financial operations at field commands.	|	|	|	|	|	|	|	-|-
15.	Standardize long and short range financial planning and reporting.	|	|	|	|	|	|	|	-|-
16.	Control/reduce CHAMPUS costs.	|	|	|	|	|	|	|	-|-

Part B: Below is the same list of objectives presented above. Indicate how well the objectives have been achieved to date.

OBJECTIVE	LEVEL OF ACHIEVEMENT							
	High			Moderate			Little	No Opinion
	7	6	5	4	3	2	1	0
1. Transfer professional expertise to MTF's.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
2. Decentralize Authority/Operations to MTF's.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
3. Centralize Authority/Operations at BUMED/HSO's.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
4. Improve communication and coordination by shortening the Chain-of-Command.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
5. Standardize internal organizational structure/operations of Field Commands.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
6. Shield Navy Medicine from overall Defense budget reductions.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
7. Make GME the Navy Medicine's #1 priority.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
8. Enhance the command/control of the Surgeon General.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
9. Make the Line responsible for the provision of medical care.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
10. Create a structure for ongoing Management Assist Visits from upper echelons	|---|	|---|	|---|	|---|	|---|	|---|		-|-
11. Increase budget flexibility at the MTF's by the removal of SAG restrictions.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
12. Establish formal mechanisms at all commands for planning/managing change.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
13. Stimulate creative management thinking and innovative practices.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
14. Minimize reorganization's impact on daily financial operations at field commands.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
15. Standardize long and short range financial planning and reporting.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
16. Control/reduce CHAMPUS costs.	|---|	|---|	|---|	|---|	|---|	|---|		-|-

SECTION IV Comparative Status of the Medical Department:

For each of the following areas, indicate how you view the Navy Medical Department today in comparison to the two year period (1986 & 1987) prior to the convening of the Blue Ribbon Panel. Make your comparison based upon changes that occurred as a result of the reorganization, and not some other concurrent management initiative. (Mark scale with an "X")

AREA	STATUS							
	Better Off			The Same			Worse Off	No Opinion
	7	6	5	4	3	2	1	0
1. Fair share of DOD Resources.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
2. Fair share of DOD Personnel.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
3. Quality of Leadership:								
a. at upper echelons	|---|	|---|	|---|	|---|	|---|	|---|		-|-
b. at the Field Commands	|---|	|---|	|---|	|---|	|---|	|---|		-|-
4. Organizational Structure								
a. of Navy Medicine	|---|	|---|	|---|	|---|	|---|	|---|		-|-
b. of the Field Commands	|---|	|---|	|---|	|---|	|---|	|---|		-|-
5. Funding Flow from BUMED to the field.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
6. Access to care for beneficiaries.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
7. Clarity of mission for Navy Medicine.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
8. Control of CHAMPUS.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
9. Long/short-range Financial Planning.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
10. Line involvement/responsibility for the provision of medical care.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
11. Stability of the organizational structure of Navy Medicine.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
12. Daily management of financial operations.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
13. Upper echelon support to field commands.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
14. Ability of Navy Medicine to respond to internal/external forces for change.	|---|	|---|	|---|	|---|	|---|	|---|		-|-
15. Overall morale/climate within the Medical Department.	|---|	|---|	|---|	|---|	|---|	|---|		-|-

SECTION V Narrative input:

This section gives you is an opportunity to provide other information, you feel would be valuable when analyzing the 1989 reorganization from the perspective of the financial community.

Briefly answer the following: (attach additional sheets if required)

(1) How do you feel field level personnel can best provide input for managing change efforts to upper echelons?

(2) How do you feel field level TQL programs can be integrated into the change process?

(3) What mechanisms/processes should Navy Medicine utilize/develop to address future internal/external forces for change?

(4) Other Comments:

APPENDIX B. DATA TABLES

This appendix contains summary data tables of surveys which meet the following criteria:

- Surveys were returned by Financial Management Professionals who were working for the Navy Medical Department on 30 September 1989.
- Surveys were completed in accordance with survey instructions.

A. Table B-1

The format for this table follows a condensed version of the survey questionnaire. The full questions upon which the tables are based can be found in Appendix A.

All averages were computed disregarding responses of 'No Opinion'. The total number of surveys used to calculate the average is given to the left of the average itself.

B. Tables B-2 through B-4

These tables present a summary of the responses for the narrative questions in Section V of the survey questionnaire.

TABLE B-1: SURVEY RESULTS: ALL RECORDS

Records in Strata: 107

SECTION I:

1. AVG YEARS OF SERVICE: 16.9 2. AVG YEARS AS NAVY FIN MGR: 8.0 3. TOTAL IN NAVMED 1989: 100%

4. RANK IN 1989: O4 and above: 28% O3 and below: 65% GS-12 and above: 6% GS-11 and below: 1%
   RANK IN 1991: O4 and above: 44% O3 and below: 50% GS-12 and above: 7% GS-11 and below: 0%

5. DUTY STATION IN 1989: NAVMEDCOM: 17% GEOCOM: 12% MTF: 36% DTF: 13% Other: 21% Out-CONUS: 16%
   DUTY STATION IN 1991: BUMED: 12% HSO: 7% MTF: 47% DTF: 12% Other: 21% Out-CONUS: 19%

SECTION II:

1. CAUSES OF REORGANIZATION

47%	CHAMPUS
88%	LINE PERCEPTIONS
44%	GEOCOM OPERATION
17%	DOD BUDGET
47%	ACCESS TO CARE
7%	DECLINING GME

2. PRIMARY CHANGE AGENT

15%	SG
16%	FLEET CMDRS
3%	MTF CMDRS
37%	CNO
7%	BENEFICIARIES
21%	NAVY IG

3. FOA&M DEVELOPER

31%	SG
6%	FLEET CMDRS
12%	MTF CMDRS
3%	MED-01
9%	MAT TEAMS
18%	BUMED TEAM
15%	BRF

4. SOURCES/VALUE OF INFO

30%/ 6%	MEDIA
27%/ 8%	BUMED ROADSHOW
64%/ 30%	PERS CONTACTS
17%/ 3%	MAT TEAM VISIT
74%/ 32%	WRITTEN COMMUN
48%/ 21%	INTERNAL BRIEF

6. TOTAL READ/SEEN BRF REPORT: 84%

7. TOTAL WITH FORMAL CHANGE COMMITTEE: 40%

8. COMMAND EFFECTIVENESS:

	# / AVG
(1) DETERMINING OBJECTIVES:	89 / 4.3
(2) COMMUNICATING OBJECTIVES:	88 / 4.0
(3) IMPLEMENTING OBJECTIVES:	88 / 4.1

9. BUMED EFFECTIVENESS:

	# / AVG
(1) COMMUNICATING CAUSES:	97 / 3.4
(2) SETTING OBJECTIVES:	94 / 3.6
(3) COMMUNICATING OBJECTIVES:	94 / 3.4
(4) DEMONSTRATING COMMITMENT:	95 / 3.6
(5) GAINING COMMITMENT:	94 / 3.4
(6) SEEKING FEEDBACK:	90 / 3.0
(7) OVERALL CHANGE EFFORT:	96 / 3.1

SECTION III:

	IMPORTANCE # / AVG	ACHIEVEMENT # / AVG
1. TRANSFER EXPERTISE:	98 / 4.6	94 / 3.6
2. DECENTRALIZE:	100 / 4.5	97 / 3.6
3. CENTRALIZE:	101 / 3.6	95 / 4.0
4. CHAIN-OF-COMMAND:	103 / 4.4	101 / 2.9
5. STANDARD STRUCTURE:	102 / 4.1	99 / 3.0
6. PREVENT BUDGET CUT:	102 / 4.6	100 / 3.8
7. GME #1 PRIORITY:	100 / 4.0	91 / 4.0
8. COMMAND/CONTROL SG:	100 / 4.2	97 / 3.7
9. LINE INVOLVEMENT:	102 / 4.0	101 / 3.0
10. MAT CREATION:	99 / 3.5	95 / 3.0
11. REMOVE SAG RESTRAINTS:	102 / 4.2	100 / 3.9
12. PLANNING MECHANISM:	100 / 4.0	98 / 3.0
13. STIMULATE MANAGEMENT:	103 / 4.2	101 / 3.3
14. MINIMIZE IMPACT:	101 / 4.0	100 / 3.6
15. STANDARDIZE PLANNING:	103 / 4.2	100 / 3.0
16. CONTROL CHAMPUS:	101 / 4.7	98 / 2.7

SECTION IV:

	STATUS # / AVG
1. DOD RESOURCES:	93 / 4.5
2. DOD PERSONNEL:	93 / 4.2
3A. LEADER QUALITY UPPER:	97 / 4.1
3B. LEADER QUALITY FIELD:	95 / 4.3
4A. ORG STRUC NAVY MED:	96 / 3.7
4B. ORG STRUC FIELD:	97 / 3.9
5. FUNDING FLOW:	96 / 3.9
6. ACCESS TO CARE:	95 / 4.1
7. MISSION CLARITY:	96 / 4.0
8. CONTROL OF CHAMPUS:	96 / 3.4
9. FINANCIAL PLANNING:	95 / 3.7
10. LINE INVOLVEMENT:	95 / 4.2
11. STABILITY:	95 / 3.4
12. DAILY MANAGING:	97 / 4.0
13. UPPER LEVEL SUPPORT:	97 / 3.8
14. RESPONSE TO CHANGE:	98 / 3.8
15. OVERALL CLIMATE:	98 / 3.9

TABLE B-2: SUMMARY OF QUALITATIVE DATA: QUESTION 1

How can Field personnel best provide input for managing change to upper echelons?

	METHOD	Number of times mentioned
1.	Annual Fin Mgmt Conferences	16
2.	Open Lines of Communication	13
3.	Proper use of Chain-of-Command	11
4.	Point Papers up Chain-of-Command	10
5.	Electronic Mail	6
6.	Direct interface with Line	5
7.	Eliminate BUMED Micromanagement	5
8.	BUMED Field visits	4
9.	Centralized Communication Control	3
10.	Reestablish GEOCOMs	3
11.	Field surveys	3
12.	Field testing/evaluation of change	2
13.	Communication with HSO Controllers	2
14.	Increased Field input to POM	2
15.	Through coordinated planning	2
16.	As part of TQL	2
17.	Increased Field/BUMED rotation	2
18.	Centralized goal management	2
19.	Field participation on IG team	1
20.	Standardized financial operations	1
21.	Anonymous suggestions	1
22.	System change request	1
23.	Focus groups	1
24.	There is no way	1

TABLE B-3: SUMMARY OF QUALITATIVE DATA: QUESTION 2

How can field level TQL programs be integrated into the change process?

	Method	Number of times mentioned
1.	By adopting TQL as a way of life	11
2.	Never, TQL is a myth	10
3.	When BUMED itself practices TQL	9
4.	Through adequate training	6
5.	When COs embrace TQL	5
6.	Through adequate resource allocation	4
7.	When used for upward communication	4
8.	By sharing experiences with others	4
9.	Through PAT teams	4
10.	Through goal management	3
11.	TQL conferences	1
12.	CO's conferences	1
13.	With Total Quality Attitudes	1
14.	Participative Mgmt/Quantitative Analysis	1
15.	Through long range planning	1

TABLE B-4: SUMMARY OF QUALITATIVE DATA: QUESTION 3

What Mechanisms or processes should Navy Medicine develop or utilize to address internal and external forces for change?

	Methods	Number of Times Mentioned
1.	Standardized long range planning	13
2.	Establish open lines of communication	10
3.	Reduce BUMED to a technical advisor	6
4.	Active TQL program	5
5.	Increased training in management skills	3
6.	Standard financial planning/reporting	3
7.	Get deadwood out of Medical Dept	2
8.	Stop reorganizing	2
9.	Improved information systems	2
10.	Marketing	2
11.	Centralized goal management	2
12.	Survey questionnaires	2
13.	Permit innovation in the field	2
14.	Participative management	1
15.	Pat Teams	1
16.	Get Doctors out of management	1
17.	Adopt multi-year funding	1
18.	Abandon JCHO accreditation process	1
19.	Eliminate multiple chain-of-cmds	1
20.	Establish Line control over promotions	1
21.	Comprehensive officer record reviews	1
22.	Remove line control of Navy Medicine	1
23.	Concentrate on getting the job done	1
24.	Increase Out-Service education	1
25.	More liaison with Line	1
26.	More coordination between BUMED codes	1
27.	Give RLC control of resources	1
28.	Eliminate BUMED entirely	1
29.	Increase manning of Admin functions	1
30.	Active Resource Management Council	1
31.	Push PPBS to activity level	1
32.	Concentrate on Family Medicine	1
33.	Newsletters	1
34.	Surgeon General visits to the field	1
35.	Direct field input to planning process	1

APPENDIX C. DOCUMENTATION REVIEWED

1. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Initial Meeting of the Flag Level Working Group, 25 May 1988.

2. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Second Meeting of the Flag Level Working Group, 07 June 1988.

3. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Third Meeting of the Flag Level Working Group, 20 June 1988.

4. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Fourth Meeting of the Flag Level Working Group, 22 July 1988.

5. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Fifth Meeting of the Flag Level Working Group, 26 July 1988.

6. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Sixth Meeting of the Flag Level Working Group, 07 September 1988.

7. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Seventh Meeting of the Flag Level Working Group, 07 October 1988.

8. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Eighth Meeting of the Flag Level Working Group, 05 December 1988.

9. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Ninth Meeting of the Flag Level Working Group, 31 January 1989.

10. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Tenth Meeting of the Flag Level Working Group, 15 February 1989.

11. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Eleventh Meeting of the Flag Level Working Group, 12 April 1989.

12. Department of the Navy, Annual Report of the Surgeon General Jul 88 - Aug 89.

13. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Initial Meeting of the Medical Blue Ribbon Panel, 24 June 1988.

14. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Second Meeting of the Medical Blue Ribbon Panel, 04 August 1988.

15. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Third Meeting of the Medical Blue Ribbon Panel, 25 August 1988.

16. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Fourth Meeting of the Medical Blue Ribbon Panel, 20 October 1988.

17. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Fifth Meeting of the Medical Blue Ribbon Panel, 16 February 1989.

18. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Record, Subject: Minutes of the Sixth Meeting of the Medical Blue Ribbon Panel, 04 May 1989.

19. Department of the Navy, Briefing for the Under Secretary of the Navy, Navy Medical Department Reorganization, 07 SEP 82.

20. Department of the Navy, Briefing for the Medical Blue Ribbon Panel, Organization and Management Task Force, 20 JUN 88.

21. Department of Defense, PAO Release, Navy Medical Blue Ribbon Panel Formed, 24 JUN 88.

22. Department of the Navy, Briefing for the Blue Ribbon Panel, Medical Blue Ribbon Panel Overview, 03 AUG 88.

23. Department of the Navy, Briefing for the Blue Ribbon Panel, Organization and Management Task Force, 04 Aug 88.

24. Department of the Navy, Briefing for the Blue Ribbon Panel, Geographic Commands Issue, 25 Aug 88.

25. Department of the Navy, Briefing for the Blue Ribbon Panel, Organization and Management Task Force, 19 OCT 88.

26. Department of the Navy, Briefing for the Blue Ribbon Panel, Medical Blue Ribbon Panel Overview, 11 APR 89.

27. Department of the Navy, Briefing for the Blue Ribbon Panel, MAT Progress Report, 04 MAY 89.

28. Department of the Navy, Briefing for the Blue Ribbon Panel, BRP Medical Organization Implementation, 04 May 89.

29. Department of the Navy, Briefing for the Blue Ribbon Panel, Medical Organization Implementation, 09 JUN 89.

30. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Distribution, Minutes of the Sixth Meeting of the Flag Level Medical Working Committee, 28 FEB 90.

31. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Distribution, Minutes of the Eighth Meeting of the Flag Level Medical Working Committee, 18 JUL 90.

32. Department of the Navy, Office of the Chief of Naval Operations, Memorandum for the Distribution, Minutes of the Ninth Meeting of the Flag Level Medical Working Committee, 10 SEP 90.

33. Department of the Navy, Bureau of Medicine and Surgery, BUMED INST 5450.156 Change 1, Mission and Functions of Naval Healthcare Support Offices, 23 JUL 91.

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3. Department of the Navy, Final Report of the Medical Blue Ribbon Panel, 21 November 1988.

4. Department of the Navy, Final Report of the Management Assist Teams, undated draft.

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